

111TH CONGRESS  
1ST SESSION

# S. 790

To improve access to health care services in rural, frontier, and urban underserved areas in the United States by addressing the supply of health professionals and the distribution of health professionals to areas of need.

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## IN THE SENATE OF THE UNITED STATES

APRIL 2, 2009

Mr. BINGAMAN (for himself, Mr. CASEY, Mr. KOHL, and Mr. UDALL of New Mexico) introduced the following bill; which was read twice and referred to the Committee on Finance

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## A BILL

To improve access to health care services in rural, frontier, and urban underserved areas in the United States by addressing the supply of health professionals and the distribution of health professionals to areas of need.

1       *Be it enacted by the Senate and House of Representa-*  
2       *tives of the United States of America in Congress assembled,*

3       **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4       (a) SHORT TITLE.—This Act may be cited as the  
5       “Health Access and Health Professions Supply Act of  
6       2009” or “HAHPSA 2009”.

1 (b) TABLE OF CONTENTS.—The table of contents of  
 2 this Act is as follows:

Sec. 1. Short title; table of contents.  
 Sec. 2. Findings.

#### TITLE I—AMENDMENTS TO THE SOCIAL SECURITY ACT

Sec. 101. Permanent National Health Workforce Commission.  
 Sec. 102. State health workforce centers program.  
 Sec. 103. Medicare medical home service and training pilot program.  
 Sec. 104. Improvements to payments for graduate medical education under  
 medicare.  
 Sec. 105. Distribution of resident trainees in an emergency.  
 Sec. 106. Authority to include costs of training of psychologists in payments to  
 hospitals for approved educational activities under Medicare.

#### TITLE II—AMENDMENTS TO THE PUBLIC HEALTH SERVICE ACT

Sec. 201. Expansion of National Health Service Corps Programs.  
 Sec. 202. National Health Service Corps Scholarship Program for Medical,  
 Dental, Physician Assistant, Pharmacy, Behavioral and Mental  
 Health, Public Health, and Nursing Students in the United  
 States Public Health Sciences Track in Affiliated Schools.  
 Sec. 203. Federal medical facility grant program and program assessments.  
 Sec. 204. Health professions training loan program.  
 Sec. 205. United States Public Health Sciences Track.  
 Sec. 206. Medical education debt reimbursement for physicians of the Veterans  
 Health Administration.

#### TITLE III—HEALTH PROFESSIONAL TRAINING PIPELINE PARTNERSHIPS PROGRAM

Sec. 301. Grants to prepare students for careers in health care.

### 3 **SEC. 2. FINDINGS.**

4 (a) FINDINGS RELATED TO HEALTH CARE ACCESS  
 5 IN RURAL, FRONTIER, AND URBAN UNDERSERVED  
 6 AREAS OF THE UNITED STATES.—Congress finds the fol-  
 7 lowing:

8 (1) The United States does not have a cohesive  
 9 or coordinated approach to addressing health work-  
 10 force shortages and problems with reliable access to  
 11 quality, affordable health care.

1           (2) There are 50,000,000 citizens of the United  
2 States living in areas that are designated under sec-  
3 tion 332(a)(1)(A) of the Public Health Service Act  
4 as health professional shortage areas.

5           (3) The population of the United States will  
6 grow by 25,000,000 each decade.

7           (4) The number of individuals over 65 years of  
8 age in the United States will double between 2000  
9 and 2030, with such individuals accounting for 20  
10 percent of the total population of the United States  
11 in 2030.

12           (5) Individuals over 65 years of age have twice  
13 as many doctor visits as those individuals under 65  
14 years of age, resulting in an increase in the demand  
15 for physicians, physician assistants, pharmacists be-  
16 havioral and mental health professionals, nurses,  
17 and dentists.

18           (6) The rates of chronic diseases (such as dia-  
19 betes) are increasing in the population of the United  
20 States.

21           (7) There are 47,000,000 citizens of the United  
22 States who do not have health insurance, and over  
23 130,000,000 individuals within the United States  
24 who do not have dental insurance. Those individuals

1 who are uninsured have limited access to health  
2 care.

3 (8) Academic health centers, Federal medical  
4 facilities, and teaching hospitals provide a substan-  
5 tial percentage of safety net services in the United  
6 States to uninsured and underinsured populations  
7 and to those individuals who have 1 or more chronic  
8 diseases. Such centers, facilities, and teaching hos-  
9 pitals provide those safety net services while concur-  
10 rently providing for the training of health profes-  
11 sionals.

12 (9) The pipeline for the education of health pro-  
13 fessionals—

14 (A) begins and often ends in urban areas;

15 (B) does not reliably include Federal sup-  
16 port for nonphysician training;

17 (C) does not incorporate modern training  
18 venues and techniques, including community-  
19 based ambulatory sites; and

20 (D) discourages interdisciplinary, team,  
21 and care coordination models as a result of re-  
22 strictive regulations.

23 (10) Health reform must include measures to  
24 transform the health delivery system to assure ac-

cess, quality, and efficiency by utilizing contemporary models and venues of care.

(11) Reform of the health delivery system will require modernization of the training of health professionals to ensure that health professionals—

(A) practice in integrated teams in a variety of delivery venues (including inpatient and ambulatory settings and long-term care facilities) to utilize decision support and health information systems;

(B) deliver patient-centered care;

(C) practice evidence-based health care;

(D) learn performance-based compensation systems, comparative effectiveness, and costs of care across the spectrum; and

(E) deliver culturally appropriate, personalized care.

(b) FINDINGS RELATED TO ACCESS TO ORAL HEALTH.—Congress finds the following:

(1) Dental care is the number 1 unmet health care need in children, and is 1 of the top 5 unmet health care needs in adults.

(2) Over 130,000,000 citizens of the United States are without dental insurance.

1           (3) Over 45,000,000 citizens of the United  
2 States live in areas that are designated under sec-  
3 tion 332(a)(1)(A) of the Public Health Service Act  
4 as dental health professional shortage areas.

5           (4) Rural counties have less than half the num-  
6 ber of dentists per capita compared to large metro-  
7 politan areas (29 versus 62 for population of  
8 100,000).

9           (5) In 2006, over 9,000 dentists were needed in  
10 such dental health professional shortage areas.

11           (6) Between 27 and 29 percent of children and  
12 adults in the United States have untreated cavities.

13           (7) The number of dental school graduates in  
14 the United States decreased by 20 percent between  
15 1982 and 2003 and the average age of practicing  
16 dentists in the United States is 49.

17           (8) There were over 400 dental faculty vacan-  
18 cies in the school year beginning in 2006.

19           (9) In 2007, the average debt of a dental stu-  
20 dent at graduation was \$172,627.

21           (c) FINDINGS RELATED TO PHYSICIAN SHORTAGES,  
22 EDUCATION, AND DISTRIBUTION.—Congress finds the fol-  
23 lowing:

24           (1) By 2020, physician shortages are forecasted  
25 to be in the range of 55,000 to 200,000.

1           (2) Although 21 percent of the population of  
2           the United States lives in rural areas, only 10 per-  
3           cent of physicians work in rural areas and, for every  
4           1 physician who goes into practice in regions with a  
5           low supply of physicians, 4 physicians go into prac-  
6           tice in regions with a high supply of physicians.

7           (3) According to a 2004 report by Green et al.  
8           for the Robert Graham Center of the American  
9           Academy of Family Physicians, the number of appli-  
10          cants from rural areas accepted to medical school  
11          has decreased by 40 percent in the last 20 years  
12          while the number of such applications has remained  
13          the same.

14          (4) In order to respond to forecasted shortages,  
15          experts have recommended an increase between 15  
16          and 30 percent in class size at medical schools over  
17          the next 10 years.

18          (5) There are 55,000,000 citizens of the United  
19          States who lack adequate access to primary health  
20          care because of shortages of primary care providers  
21          in their communities.

22          (6) The number of graduates from medical  
23          school in the United States who choose to practice  
24          family medicine has plummeted 50 percent in less  
25          than 10 years. Without congressional intervention,

1 such decline will likely continue, and access to care  
2 in underserved areas will rapidly deteriorate. Family  
3 physicians represent 58 percent of the rural physi-  
4 cian workforce, 70 percent of non-Federal physicians  
5 in whole-county health professional shortage areas,  
6 and 78 percent of primary care physician full-time  
7 equivalents in the National Health Service Corps.

8 (7) Current trends indicate that fewer resident  
9 trainees from pediatric and internal medicine  
10 residencies pursue generalist practice at graduation.

11 (8) Funding for medical education which is pro-  
12 vided through direct Graduate Medical Education  
13 (GME) and Indirect Medical Education (IME)  
14 under the Medicare program is not transparent or  
15 accountable, nor is it aligned to the types of health  
16 professionals most needed or to the areas in which  
17 health professionals are most needed.

18 (9) Physician supply varies 200 percent across  
19 regions and there is no relationship between regional  
20 physician supply and health needs.

21 (10) The Council on Graduate Medical Edu-  
22 cation's 18th Report (issued in 2007), entitled "New  
23 Paradigms for Physician Training for Improving Ac-  
24 cess to Health Care", and 19th Report (issued in  
25 2007), entitled "Enhancing Flexibility in Graduate



1 Medical Education”, each call for changes to address  
2 the healthcare needs of the United States by remov-  
3 ing barriers to expanding and more appropriately  
4 training the physician workforce.

5 (d) FINDINGS RELATED TO NURSING SHORTAGES,  
6 EDUCATION, AND DISTRIBUTION.—Congress finds the fol-  
7 lowing:

8 (1) By 2020, nursing shortages are forecast to  
9 be in the range of 300,000 to 1,000,000 and the  
10 Bureau of Labor Statistics of the Department of  
11 Labor estimates that more than 1,200,000 new and  
12 replacement registered nurses will be needed by  
13 2014.

14 (2) Nurse vacancy rates are currently 8 percent  
15 or greater in hospitals and community health centers  
16 receiving assistance under section 330 of the Public  
17 Health Service Act, and for nursing faculty posi-  
18 tions.

19 (3) Surveys indicate that 40 percent of nurses  
20 in hospitals are dissatisfied with their work and, of  
21 nurses who graduate and go into nursing, 50 per-  
22 cent leave their first employer within 2 years.

23 (4) Nursing baccalaureate and graduate pro-  
24 grams rejected more than 40,000 qualified nursing  
25 school applicants in 2006, with faculty shortages

1 identified by such programs as a major reason for  
2 turning away qualified applicants.

3 (5) More than 70 percent of nursing schools  
4 cited faculty shortages as the primary reason for not  
5 accepting all qualified applicants into entry-level  
6 nursing programs.

7 (6) The nursing faculty workforce is aging and  
8 retiring and, by 2019, approximately 75 percent of  
9 the nursing faculty workforce is expected to retire.

10 (7) The average age of nurses in the United  
11 States is 49 and the average age of an associate pro-  
12 fessor nurse faculty member in the United States is  
13 56.

14 (8) Geriatric patients receiving care from  
15 nurses trained in geriatrics are less frequently re-  
16 admitted to hospitals or transferred from skilled  
17 nursing facilities and nursing facilities to hospitals.

18 (e) FINDINGS RELATED TO PUBLIC HEALTH WORK-  
19 FORCE SHORTAGES.—Congress finds the following:

20 (1) The United States has an estimated 50,000  
21 fewer public health workers than it did 20 years ago  
22 while the population has grown by approximately 22  
23 percent.

1           (2) Government public health departments are  
 2           facing significant workforce shortages that could be  
 3           exacerbated through retirements.

4           (3) Twenty percent of the average State health  
 5           agency's workforce will be eligible to retire within 3  
 6           years, and by 2012, over 50 percent of some State  
 7           health agency workforces will be eligible to retire.

8           (4) Approximately 20 percent of local health de-  
 9           partment employees will be eligible for retirement by  
 10          2010.

11          (5) The average age of new hires in State  
 12          health agencies is 40.

13          (6) 4 out of 5 current public health workers  
 14          have not had formal training for their specific job  
 15          functions.

16          (f) FINDINGS RELATED TO PHYSICIAN ASSISTANT  
 17          SHORTAGES.—Congress finds the following:

18               (1) The purpose of the physician assistant pro-  
 19               fession is to extend the ability of physicians to pro-  
 20               vide primary care services, particularly in rural and  
 21               other medically underserved communities.

22               (2) Physician assistants always practice medi-  
 23               cine as a team with their supervising physicians,  
 24               however, supervising physicians need not be phys-

1 ically present when physician assistants provide  
2 medical care.

3 (3) Physician assistants are legally regulated in  
4 all States, the District of Columbia, and Guam. All  
5 States, the District of Columbia, and Guam author-  
6 ize physicians to delegate prescriptive authority to  
7 physician assistants.

8 (4) In 2007, physician assistants made approxi-  
9 mately 245,000,000 patient visits and prescribed or  
10 recommended approximately 303,000,000 medica-  
11 tions.

12 (5) The National Association of Community  
13 Health Centers, the George Washington University,  
14 and the Robert Graham Center for Policy Studies in  
15 Family Medicine and Primary Care found that while  
16 the number of patients who seek care at community  
17 health centers has increased, the number of primary  
18 care providers, including physician assistants, has  
19 not. The report estimates a need for 15,500 primary  
20 health care providers to provide care at community  
21 health centers.

22 (g) FINDINGS RELATED TO MENTAL HEALTH PRO-  
23 FESSIONAL SHORTAGES.—Congress finds the following:

24 (1) The National Institute of Mental Health es-  
25 timates that 26.2 percent of citizens of the United

1 States ages 18 and older suffer from a diagnosable  
2 mental disorder. Approximately 20 percent of chil-  
3 dren in the United States have diagnosable mental  
4 disorders with at least mild functional impairment.

5 (2) The Health Resources and Services Admin-  
6 istration reports that there are 3,059 mental health  
7 professional shortage areas within the United States  
8 with 77,000,000 people living in those areas. More  
9 than 5,000 additional mental health professionals  
10 are needed to meet demand.

11 (3) According to the Department of Health and  
12 Human Services, minority representation is lacking  
13 in the mental health workforce. Although 12 percent  
14 of the population of the United States is African-  
15 American, only 2 percent of psychologists, 2 percent  
16 of psychiatrists, and 4 percent of social workers are  
17 African-American. Moreover, there are only 29 men-  
18 tal health professionals who are Hispanic for every  
19 100,000 individuals who are Hispanic in the United  
20 States, compared with 173 non-Hispanic White pro-  
21 viders for every 100,000 individuals who are non-  
22 Hispanic White in the United States.

23 (h) FINDINGS RELATED TO HEALTH PROFESSIONAL  
24 SHORTAGE AREAS.—

1           (1) In 2006, the National Health Service Corps  
2           had a total of 4,200 vacant positions in health pro-  
3           fessional shortage areas, but only 1,200 of those po-  
4           sitions were funded. For each National Health Serv-  
5           ice Corps award, there are 7 applicants.

6           (2) Community health centers receiving assist-  
7           ance under section 330 of the Public Health Service  
8           Act have expanded to serve 16,000,000 individuals  
9           in over 1,000 sites. Such community health centers  
10          have high vacancy rates for family physicians (13  
11          percent), obstetricians and gynecologists (21 per-  
12          cent), dentists, nurses, and other health profes-  
13          sionals.

14          (3) The Institute of Medicine of the National  
15          Academies has recommended that medical education  
16          and public health issues be more closely aligned, es-  
17          pecially in relation to preparedness for natural disas-  
18          ters, pandemic, bioterrorism, and other threats to  
19          public health.

20          (4) The education of health professionals must  
21          be more closely aligned with health care needs in the  
22          United States, with special attention to underserved  
23          populations and areas, health disparities, the aging  
24          population, and individuals with 1 or more chronic  
25          diseases.

1           (5) There is some duplication, and little coordi-  
 2           nation, between the Council on Graduate Medical  
 3           Education (related to the physician workforce), the  
 4           National Advisory Committee on Nursing Programs  
 5           (related to the nursing workforce), the Advisory  
 6           Committee on Training in Primary Care Medicine  
 7           and Dentistry, and other advisory committees and  
 8           councils.

9           (6) The Association of Academic Health Cen-  
 10          ters calls for making the health workforce of the  
 11          United States a priority domestic policy issue and  
 12          creating a national health workforce planning body  
 13          that engages Federal, State, public, and private  
 14          stakeholders.

## 15       **TITLE I—AMENDMENTS TO THE** 16       **SOCIAL SECURITY ACT**

### 17       **SEC. 101. PERMANENT NATIONAL HEALTH WORKFORCE** 18       **COMMISSION.**

19          (a) ESTABLISHMENT.—There is hereby established  
 20          the Permanent National Health Workforce Commission  
 21          (in this section referred to as the “Commission”).

22          (b) DUTIES.—

23               (1) REVIEW OF FEDERAL POLICIES AND AN-  
 24          NUAL REPORTS.—

1 (A) REVIEW.—The Commission shall re-  
2 view Federal policies with respect to the train-  
3 ing, financing, and distribution of the health  
4 professional workforce, particularly with respect  
5 to such workforce in rural, frontier, and urban  
6 underserved areas, including the specific topics  
7 described in paragraph (2). Such review shall  
8 include a comprehensive analysis and reporting  
9 of—

10 (i) the most recent  
11 COHPPERDDUST Annual Report;

12 (ii) the number of medical students  
13 and residents, physician assistant students,  
14 pharmacy students and residents, behav-  
15 ioral and mental health students and resi-  
16 dents, dental students and residents, nurs-  
17 ing students and advance practice nursing  
18 trainees, and other health professionals in  
19 need of training, the rates of payment for  
20 such training; and the methodologies for  
21 funding such training;

22 (iii) how to align payments for direct  
23 graduate medical education costs under  
24 section 1886(h) of the Social Security Act  
25 (42 U.S.C. 1395ww(h)) and payments for



1 the indirect costs of medical education  
2 under section 1886(d)(5)(B) of the Social  
3 Security Act (42 U.S.C. 1395ww(d)(5)(B))  
4 with other Federal and State subsidies and  
5 payments for health professions education  
6 with desired outcomes for the health pro-  
7 fessional workforce;

8 (iv) whether Federal medical facilities  
9 should be permitted to train health profes-  
10 sionals with support paid directly by the  
11 entity sponsoring the health professional;

12 (v) whether the establishment of  
13 transparent, accountable Federal payment  
14 policies for training health professionals  
15 would ensure that the types of health pro-  
16 fessionals trained and the distribution of  
17 such health professionals would meet the  
18 health care needs of the population of the  
19 United States;

20 (vi) the feasibility of establishing a  
21 National Health Professions Education  
22 Trust Fund to ensure an open and fair  
23 system of Federal, State, and private sup-  
24 port for providing education for health pro-  
25 fessionals; and

1 (vii) any other issues related to such  
 2 Federal policies as the Commission deter-  
 3 mines appropriate.

4 (B) COHPPERDDUST ANNUAL RE-  
 5 PORTS.—Not later than each of January 1 of  
 6 each year (beginning with 2012) the Commis-  
 7 sion shall submit to the Secretary and to Con-  
 8 gress a report containing—

9 (i) the results of the review conducted  
 10 under subparagraph (A); and

11 (ii) recommendations—

12 (I) with respect to the Health  
 13 Professions Pipeline, Education, Re-  
 14 search, Diversity & Distribution to  
 15 Underserved Areas Utilizing Service/  
 16 Training Models; and

17 (II) for such legislation or admin-  
 18 istrative action, including regulations,  
 19 as the Commission determines appro-  
 20 priate.

21 (2) SPECIFIC TOPICS DESCRIBED.—

22 (A) PAYMENTS FOR HEALTH PROFESSIONS  
 23 EDUCATION.—Specifically, the Commission  
 24 shall review, with respect to the training, fi-

nancing, and distribution of the health professional workforce, the following:

(i) The regular update, revision, and standardization of hospital-specific and sponsoring institution-specific base-period per resident amounts and cost reporting periods for payments for direct graduate medical education costs under section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) and payments for the indirect costs of medical education under section 1886(d)(5)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)).

(ii) The feasibility of the Secretary, subject to review by the Commission, granting a waiver under the Medicare program, such as the waiver granted to the Utah Medical Education Commission, which would allow States flexibility to utilize funding under titles XVIII, XIX, and XXI of the Social Security Act for direct graduate medical education and indirect graduate medical education to support coordinated and comprehensive health workforce training innovations.

(iii) Replacement of the current methodology for making payments for such direct graduate medical education costs and such indirect costs of medical education with a workforce adjustment payment, based on a Sustainable Growth Rate formula or a prospective payment system, under which—

(I) payments would be made directly to the sponsoring institution where such education is provided; and

(II) payments would be separated to reflect the costs to the professional and facility components of such education.

(iv) The establishment of standards for the financing of education for health professionals who are not physicians.

(v) The expansion of the definition, for purposes of making payments for health professions education (including such direct graduate medical education costs and such indirect costs of medical education), of the term “sponsoring institution”, which traditionally has been a

1 teaching hospital or medical school, to in-  
2 clude nonteaching hospital-based entities  
3 (such as managed care organizations and  
4 public and private healthcare consortia)  
5 that are capable of assembling all of the  
6 resources necessary for effectively pro-  
7 viding the training and education required  
8 to address healthcare access, quality, and  
9 costs and to meet workforce needs.

10 (vi) The provision of health profes-  
11 sions education by nonteaching hospital-  
12 based entities (including rural health clin-  
13 ics (as defined in subsection (aa)(2) of sec-  
14 tion 1861 of the Social Security Act (42  
15 U.S.C. 1395x)), community health centers  
16 (as defined in section 330 of the Public  
17 Health Service Act (42 U.S.C. 254b)), and  
18 Federally qualified health centers (as de-  
19 fined in subsection (aa)(4) of such section  
20 1861) that are not sponsoring institutions  
21 (as defined under clause (v)) as affiliates  
22 of the sponsoring institution for purposes  
23 of providing more limited, but highly valu-  
24 able clinical training.

1           (vii) The establishment of incentives  
2           to promote interdisciplinary, team-based,  
3           and care coordination-based education of  
4           health professionals, including incentives to  
5           encourage the development of health infor-  
6           mation technology (such as a repository of  
7           consumer health status information in  
8           computer processable form) which can be  
9           used for diagnosis, management, and treat-  
10          ment and includes price and cost informa-  
11          tion.

12          (viii) Adjustment to the Medicare caps  
13          on graduate medical education positions to  
14          increase the number of primary care resi-  
15          dents, general dentistry residents, geriatric  
16          fellowship trainees, and other health pro-  
17          fessionals trained in Federal medical facili-  
18          ties.

19          (ix) The development of pay-for-per-  
20          formance methodologies for payments for  
21          health professions education (including  
22          such direct graduate medical education  
23          costs, payments for such indirect costs of  
24          medical education, and disproportionate  
25          share payments under section

1 1886(d)(5)(F) of the Social Security Act  
2 (42 U.S.C. 1395ww(d)(5)(F))) to—

3 (I) increase payments to spon-  
4 soring institutions and the affiliates of  
5 such institutions that achieve desired  
6 outcomes; and

7 (II) reduce payments to such in-  
8 stitutions and such affiliates that do  
9 not perform.

10 (x) The correlation between Federal  
11 policies with respect to the training, fi-  
12 nancing, and distribution of the health pro-  
13 fessional workforce and specific evidence-  
14 based, measurable, and comparative out-  
15 comes across sponsoring institutions and  
16 the affiliates of such institutions.

17 (xi) Disproportionate share payments  
18 under section 1886(d)(5)(F) of the Social  
19 Security Act (42 U.S.C. 1395ww(d)(5)(F))  
20 made to service and training institutions  
21 that provide safety net access, community-  
22 based outreach programs, measurable and  
23 transparent community benefit, and  
24 planned financial assistance to low-income  
25 patients, Medicare beneficiaries, and

1 underinsured (including uninsured) indi-  
2 viduals in rural, frontier, and urban under-  
3 served areas.

4 (xii) The establishment of a workforce  
5 adjustment payment under the Medicare  
6 program under title XVIII of the Social  
7 Security Act, the Medicaid program under  
8 title XIX of such Act, the State Children's  
9 Health Insurance Program under title XXI  
10 of such Act, and other publicly funded  
11 health insurance programs to support  
12 training programs for health professionals  
13 in Federal medical facilities, under which  
14 such workforce adjustment payment would  
15 be made directly to the sponsoring institu-  
16 tion. Such payment would, as the Sec-  
17 retary determines appropriate, in consulta-  
18 tion with the Commission, replace or sup-  
19 plement the provisions under clause (iii).

20 (B) DATA COLLECTION AND REVIEW.—

21 Specifically, the Commission shall review, with  
22 respect to the adequacy, supply, and distribu-  
23 tion of undergraduate and graduate education  
24 programs for health professionals, the following:



(i) Available data on the adequacy, supply, and distribution of such education programs for physicians, physician assistants, nurses, dentists, psychologists, pharmacists, behavioral and mental health professionals (as defined in section 331(a)(3)(E)(i) of the Public Health Service Act (42 U.S.C. 254d(a)(3)(E)(i)), public health professionals, and other health professionals, including data collected under the State Health Workforce Centers Program established under section 102.

(ii) Processes for improving the collection of data on health professionals, including the collection of more consistent, independent, and comprehensive data from entities (such as State licensure boards) to inform health professions workforce issues. In conducting such review, the Commission shall determine the costs of implementing such data collection.

### (3) CONDUCT OF HEARINGS.—

(A) IN GENERAL.—The Commission shall conduct hearings on health professions education to assess performance, identify barriers,

1 speed approval of innovative programs, improve  
 2 flexibility, and reduce bureaucratic obstacles  
 3 balancing hospital training while emphasizing  
 4 sustained affiliation agreements with commu-  
 5 nity-based, interdisciplinary, team, and care  
 6 management methodologies and education de-  
 7 signed to improve quality and efficiency of pa-  
 8 tient care across the care delivery system.

9 (B) TESTIMONY.—In conducting hearings  
 10 under subparagraph (A), the Commission shall  
 11 solicit testimony from the Accreditation Council  
 12 for Graduate Medical Education, Residency Re-  
 13 view Committees, and other appropriate organi-  
 14 zations that accredit education programs for  
 15 health professionals.

16 (C) INFORMATION FROM FEDERAL AGEN-  
 17 CIES.—

18 (i) IN GENERAL.—The Commission  
 19 may secure directly from a Federal agency  
 20 such information as the Commission con-  
 21 siders necessary to carry out this section.

22 (ii) PROVISION OF INFORMATION.—  
 23 The head of the agency shall provide the  
 24 information to the Commission at the re-

1                   quest of the Chairperson of the Commis-  
2                   sion.

3                   (4) REDUCING HEALTH PROFESSIONAL ISOLA-  
4           TION AND BUILDING COMMUNITY HEALTH PROFES-  
5           SIONAL TRAINING INFRASTRUCTURE.—

6                   (A) IDENTIFICATION OF PROGRAMS.—The  
7           Commission shall identify programs to reduce  
8           health professional isolation and build commu-  
9           nity health professional training infrastructure  
10          in rural, frontier, and urban underserved areas  
11          through continuing education (including con-  
12          tinuing education utilizing information tech-  
13          nology, such as telehealth and health informa-  
14          tion technology), mentoring, and precepting ac-  
15          tivities.

16                  (B) ANALYSIS.—The Commission shall ex-  
17          amine—

18                       (i) whether the establishment of re-  
19                      gional or statewide Health Advice Lines  
20                      would reduce after-hours calls responsibil-  
21                      ities for overworked health professionals in  
22                      remote sites with few health professionals  
23                      available to fulfill such responsibilities;

1 (ii) what support should be given to  
 2 health professionals fulfilling such respon-  
 3 sibilities—

4 (I) in hospitals and emergency  
 5 departments in areas designated  
 6 under section 332 of the Public  
 7 Health Service Act as health profes-  
 8 sional shortage areas;

9 (II) under practice relief pro-  
 10 grams that allow health professionals  
 11 practicing in such areas to have their  
 12 practice and calls covered when they  
 13 are ill, pursuing continuing education,  
 14 or taking a vacation; and

15 (III) with respect to field faculty  
 16 development to become supervisors,  
 17 mentors, and preceptors for health  
 18 professional students and trainees;

19 (iii) support structures (such as Area  
 20 Health Education Centers) for health pro-  
 21 fessionals; and

22 (iv) whether the establishment of  
 23 Rural Health Education Offices, based on  
 24 the model of agricultural extension offices,  
 25 would—

1 (I) help build community health  
 2 professional service and training ca-  
 3 pacity; and

4 (II) spur local economic develop-  
 5 ment.

6 (5) DEVELOPMENT OF GUIDING PRINCIPLES  
 7 AND ACCOUNTABILITY STANDARDS.—The Commis-  
 8 sion shall develop guiding principles and account-  
 9 ability standards for Federal, State, and private sec-  
 10 tor education of health professionals. Such guide-  
 11 lines shall be crafted to assure that the Federal in-  
 12 vestment in the education of health professionals is  
 13 a public good, regardless of whether a portion of  
 14 such education is funded by other sources.

15 (6) IDENTIFICATION OF STATE AND REGIONAL  
 16 HEALTH PROFESSIONS EDUCATION COMMISSIONS.—  
 17 The Commission shall identify State and regional  
 18 Health Professions Education Centers. The Commis-  
 19 sion shall enter into agreements with such Centers  
 20 under which the Centers shall provide data and re-  
 21 ports to the Commission to provide a balanced and  
 22 adequate assessment of the entire Nation's  
 23 healthcare workforce.

24 (c) SECRETARIAL RESPONSIBILITIES.—Not later  
 25 than 18 months after the date of enactment of this Act,

1 the Secretary shall, in consultation with the Commission,  
 2 and through negotiated rulemaking, promulgate regula-  
 3 tions to address the matters reviewed under clauses (i)  
 4 through (vii) of subsection (b)(1)(A), as the Secretary de-  
 5 termines appropriate to address access and health profes-  
 6 sional shortages and needs identified by the Commission  
 7 with respect to titles XVIII, XIX, and XXI of the Social  
 8 Security Act.

9 (d) MEMBERSHIP.—

10 (1) NUMBER OF APPOINTMENT.—The Commis-  
 11 sion shall be composed of 20 members appointed by  
 12 the Comptroller General of the United States.

13 (2) QUALIFICATIONS.—The membership of the  
 14 Commission shall include representatives of—

15 (A) dentists and dental hygienists who  
 16 practice in urban underserved and rural areas;

17 (B) primary care providers who practice in  
 18 urban underserved and rural areas;

19 (C) nurses and physician assistants who  
 20 practice in urban underserved and rural areas;

21 (D) psychologists and other behavioral and  
 22 mental health professionals (as defined in sec-  
 23 tion 331(a)(3)(E)(i) of the Public Health Serv-  
 24 ice Act (42 U.S.C. 254d(a)(3)(E)(i)) who prac-  
 25 tice in urban underserved and rural areas;

1 (E) public health professionals;

2 (F) clinical pharmacists who practice in a  
3 Federal market or are sole-community pro-  
4 viders;

5 (G) national and specialty physician and  
6 nursing organizations;

7 (H) schools of medicine, osteopathy, and  
8 nursing, educational programs for public health  
9 professionals, behavioral and mental health pro-  
10 fessionals (as so defined), and physician assist-  
11 ants, public and private teaching hospitals, and  
12 ambulatory health facilities, including Federal  
13 medical facilities;

14 (I) health insurers;

15 (J) business;

16 (K) labor; and

17 (L) any other health professional organiza-  
18 tion or practice site the Comptroller General de-  
19 termines appropriate.

20 (e) STAFF.—

21 (1) IN GENERAL.—The Comptroller General of  
22 the United States shall provide for the appointment  
23 of an executive director, deputy director, and such  
24 other additional personnel as are necessary to enable

1 the Commission to perform the duties of the Com-  
2 mission.

3 (2) COMPENSATION.—

4 (A) IN GENERAL.—Except as provided in  
5 subparagraph (B), the Comptroller General of  
6 the United States may fix the compensation of  
7 the executive director, deputy director, and  
8 other personnel without regard to the provisions  
9 of chapter 51 and subchapter III of chapter 53  
10 of title 5, United States Code, relating to classi-  
11 fication of positions and General Schedule pay  
12 rates.

13 (B) MAXIMUM RATE OF PAY.—The rate of  
14 pay for the executive director, deputy director,  
15 and other personnel shall not exceed the rate  
16 payable for level V of the Executive Schedule  
17 under section 5316 of title 5, United States  
18 Code.

19 (3) DETAIL OF FEDERAL GOVERNMENT EM-  
20 PLOYEES.—

21 (A) IN GENERAL.—An employee of the  
22 Federal Government may be detailed to the  
23 Commission without reimbursement.



1 (B) CIVIL SERVICE STATUS.—The detail of  
 2 the employee shall be without interruption or  
 3 loss of civil service status or privilege.

4 (4) PROCUREMENT OF TEMPORARY AND INTER-  
 5 MITTENT SERVICES.—The Commission may procure  
 6 temporary and intermittent services in accordance  
 7 with section 3109(b) of title 5, United States Code,  
 8 at rates for individuals that do not exceed the daily  
 9 equivalent of the annual rate of basic pay prescribed  
 10 for level V of the Executive Schedule under section  
 11 5316 of that title.

12 (f) POWERS.—

13 (1) HEARINGS.—The Commission may hold  
 14 such hearings, meet and act at such times and  
 15 places, take such testimony, and receive such evi-  
 16 dence as the Commission considers advisable to  
 17 carry out this section.

18 (2) INFORMATION FROM FEDERAL AGENCIES.—

19 (A) IN GENERAL.—The Commission may  
 20 secure directly from a Federal agency such in-  
 21 formation as the Commission considers nec-  
 22 essary to carry out this section.

23 (B) PROVISION OF INFORMATION.—On re-  
 24 quest of the Chairperson of the Commission,

1           the head of the agency shall provide the infor-  
2           mation to the Commission.

3           (3) POSTAL SERVICES.—The Commission may  
4           use the United States mails in the same manner and  
5           under the same conditions as other agencies of the  
6           Federal Government.

7           (4) GIFTS.—The Commission may accept, use,  
8           and dispose of gifts or donations of services or prop-  
9           erty.

10          (g) STATUS AS PERMANENT COMMISSION.—Section  
11 14 of the Federal Advisory Committee Act (5 U.S.C.  
12 App.) shall not apply to the Commission.

13          (h) DEFINITIONS.—In this section:

14           (1) COHPERDDUST ANNUAL REPORT.—The  
15           term “COHPERDDUST Annual Report” means  
16           the annual report submitted by the Commission  
17           under subsection (b)(1)(B).

18           (2) FEDERAL MEDICAL FACILITY.—The term  
19           “Federal medical facility” means a facility for the  
20           delivery of health services, and includes—

21           (A) a Federally qualified health center (as  
22           defined in section 1861(aa)(4) of the Social Se-  
23           curity Act (42 U.S.C. 1395x(aa)(4)), a public  
24           health center, an outpatient medical facility, or  
25           a community mental health center;

1 (B) a hospital, State mental hospital, facil-  
 2 ity for long-term care, or rehabilitation facility;

3 (C) a migrant health center or an Indian  
 4 Health Service facility;

5 (D) a facility for the delivery of health  
 6 services to inmates in a penal or correctional in-  
 7 stitution (under section 323 of such Act (42  
 8 U.S.C. 250)) or a State correctional institution;

9 (E) a Public Health Service medical facil-  
 10 ity (used in connection with the delivery of  
 11 health services under section 320, 321, 322,  
 12 324, 325, or 326 of such Act (42 U.S.C. 247e,  
 13 248, 249, 251, 252, or 253));

14 (F) a nurse-managed health center; or

15 (G) any other Federal medical facility.

16 (3) SECRETARY.—The term “Secretary” means  
 17 the Secretary of Health and Human Services.

18 **SEC. 102. STATE HEALTH WORKFORCE CENTERS PROGRAM.**

19 (a) ESTABLISHMENT.—The Secretary shall establish  
 20 a demonstration program (in this section referred to as  
 21 the “program”) under which the Secretary makes grants  
 22 to participating States for the operation of State Health  
 23 Workforce Centers to carry out the activities described in  
 24 subsection (c).

1       (b) PARTICIPATING STATES.—A State seeking to  
2 participate in the program shall submit an application to  
3 the Secretary containing such information and at such  
4 time as the Secretary may specify. The Secretary may only  
5 consider under the preceding sentence 1 application sub-  
6 mitted by each State which has been certified by the Gov-  
7 ernor or the chief executive officer of the State.

8       (c) USE OF FUNDS.—Grants awarded under sub-  
9 section (a) may be used to support activities designed to  
10 improve the training, deployment, and retention of critical  
11 health professionals in underserved areas and for under-  
12 served populations, including the following:

13           (1) Conducting assessments of key health pro-  
14 fessional capacity and needs. Such assessments shall  
15 be conducted in a coordinated manner that provides  
16 for the nationwide collection of health professional  
17 data.

18           (2) Convening State health professional policy-  
19 makers to review education, education financing,  
20 regulations, and taxation and compensation policies  
21 which affect the training, deployment, and retention  
22 of health professionals. A participating State may,  
23 taking into consideration the results of such reviews,  
24 develop short-term and long-term recommendations  
25 for improving the supply, deployment, and retention

1 of critical health professionals in underserved areas  
 2 and for underserved populations.

3 (d) FUNDING.—

4 (1) AUTHORIZATION OF APPROPRIATIONS.—

5 There are authorized to be appropriated  
 6 \$13,750,000 to carry out this section.

7 (2) MATCHING REQUIREMENT.—The Secretary  
 8 may require a State, in order to be eligible to receive  
 9 a grant under this section, to agree that, with re-  
 10 spect to the costs incurred by the State in carrying  
 11 out the activities for which the grant was awarded,  
 12 the State will make available (directly or through do-  
 13 nations from public or private entities) non-Federal  
 14 contributions in an amount equal to a percent of  
 15 Federal funds provided under the grant (as deter-  
 16 mined appropriate by the Secretary).

17 (e) DEFINITIONS.—In this section:

18 (1) SECRETARY.—The term “Secretary” means  
 19 the Secretary of Health and Human Services.

20 (2) STATE.—The term “State” means—

21 (A) a State;

22 (B) the District of Columbia;

23 (C) the Commonwealth of Puerto Rico;

24 and

1 (D) any other territory or possession of the  
2 United States.

3 **SEC. 103. MEDICARE MEDICAL HOME SERVICE AND TRAIN-**  
4 **ING PILOT PROGRAM.**

5 (a) EXPANSION OF MEDICARE MEDICAL HOME DEM-  
6 ONSTRATION PROJECT.—

7 (1) IN GENERAL.—The Secretary of Health and  
8 Human Services (in this section referred to as the  
9 “Secretary”) shall expand the Medicare medical  
10 home demonstration project under section 204 of  
11 Division B of the Tax Relief and Health Care Act  
12 of 2006 (Public Law 109–432; 120 Stat. 2987) by  
13 adding a Medicare medical home service and train-  
14 ing pilot program (in this section referred to as the  
15 “pilot program”) to redesign the methodologies for  
16 payments to primary care providers for coordinating  
17 the care of applicable Medicare beneficiaries. Such  
18 pilot program shall be in addition to, and run con-  
19 currently with, the Medicare medical home dem-  
20 onstration program. Except for any modifications  
21 under this section, the Secretary shall carry out the  
22 pilot program under similar terms and conditions as  
23 the Medicare medical home demonstration program.

1           (2) APPLICABLE MEDICARE BENEFICIARIES DE-  
 2           FINED.—In this section, the term “applicable Medi-  
 3           care beneficiary” means an individual who—

4                   (A) is entitled to, or enrolled for, benefits  
 5                   under part A of title XVIII of the Social Secu-  
 6                   rity Act, or is enrolled under part B of such  
 7                   title;

8                   (B) has 1 or more chronic illnesses (such  
 9                   as diabetes, hypertension, chronic obstructive  
 10                  pulmonary disease, asthma, congestive heart  
 11                  failure, end stage liver disease, and end stage  
 12                  renal disease); and

13                  (C) is in the top 2 quartiles of cost under  
 14                  the Medicare program under such title (as de-  
 15                  termined based on Medicare claims data for the  
 16                  most recent 2 years for which data is available).

17       (b) DETAILS.—

18           (1) DURATION; SCOPE.—The pilot program  
 19           shall operate during the period beginning on Janu-  
 20           ary 1, 2011, and ending on December 31, 2014, and  
 21           shall include not more than 1,000 medical home pri-  
 22           mary care providers.

23           (2) IMPLEMENTATION.—

24                   (A) IN GENERAL.—The Secretary may im-  
 25                   plement the pilot program—

1 (i) under title XVIII of the Social Se-  
 2 curity Act; or

3 (ii) subject to subparagraph (B),  
 4 under a combination of such title and  
 5 other public or private programs or organi-  
 6 zations.

7 (B) SPECIAL RULE.—In the case where the  
 8 Secretary implements the pilot program under a  
 9 combination of title XVIII of the Social Secu-  
 10 rity Act and other public or private programs or  
 11 organizations, the Secretary shall establish pro-  
 12 cedures to ensure that any funding made avail-  
 13 able under such title for the pilot program is  
 14 only used to furnish items and services to Medi-  
 15 care beneficiaries.

16 (3) PARTICIPATION OF PRIMARY CARE PRO-  
 17 VIDERS.—

18 (A) IN GENERAL.—In no case shall partici-  
 19 pation in the pilot program be limited to pri-  
 20 mary care providers in those States partici-  
 21 pating in the Medicare medical home dem-  
 22 onstration project under section 204 of Division  
 23 B of the Tax Relief and Health Care Act of  
 24 2006 (Public Law 109–432; 120 Stat. 2987).  
 25 Any primary care provider in the United States



1           that meets the requirements and definitions  
2           under this section and, if applicable, such sec-  
3           tion 204, shall be eligible to participate in the  
4           pilot program. In selecting primary care pro-  
5           viders to participate in the pilot program, the  
6           Secretary shall give preference to sites where  
7           clinical services and health professional edu-  
8           cation are provided concurrently, taking into  
9           consideration priorities of the Permanent Na-  
10          tional Health Workforce Commission estab-  
11          lished under section 101 of the Health Access  
12          and Health Professions Supply Act of 2009.

13                 (B) DEFINITION OF PRIMARY CARE PRO-  
14          VIDERS.—In this section, the term “primary  
15          care provider” means—

16                         (i) a personal physician (as defined in  
17                         subsection (c)(1) of section 204 of Division  
18                         B of the Tax Relief and Health Care Act  
19                         of 2006 (Public Law 109–432; 120 Stat.  
20                         2987), except that, in applying such defini-  
21                         tion under this section, the requirements  
22                         described in subsection (c)(2)(B) of such  
23                         section 204 shall specify that the staff and  
24                         resources of the physician may include a  
25                         team of health professionals (such as nurse

1 practitioners, clinical nurse specialists, cer-  
 2 tified nurse midwives, psychologists and  
 3 other behavioral and mental health profes-  
 4 sionals (as defined in section  
 5 331(a)(3)(E)(i) of the Public Health Serv-  
 6 ice Act (42 U.S.C. 254d(a)(3)(E)(i)), phy-  
 7 sician assistants, and other primary care  
 8 providers that meet requirements estab-  
 9 lished by the Secretary)); and

10 (ii) any other primary care provider  
 11 (such as a nurse practitioner or a physi-  
 12 cian assistant) that is subject to State li-  
 13 censure laws and the requirements of the  
 14 Secretary.

15 (C) LIMITATION ON NUMBER OF PRIMARY  
 16 CARE PROVIDERS PARTICIPATING IN THE PILOT  
 17 PROGRAM WHO ARE NOT PERSONAL PHYSI-  
 18 CIANS.—The Secretary shall ensure that the  
 19 total number of independently practicing pri-  
 20 mary care providers who are not personal physi-  
 21 cians participating in the pilot program reflects  
 22 the percentage of such primary care providers  
 23 in the United States (as determined by the Sec-  
 24 retary), not to exceed 10 percent of the total

1           number of primary care providers participating  
2           in the pilot program.

3           (4) SERVICES PERFORMED.—A primary care  
4           provider shall perform or provide for the perform-  
5           ance of at least the services described in subsection  
6           (c)(3) of such section 204 under the pilot program.

7           (c) CARE COORDINATION FEE PAYMENT METHOD-  
8           OLOGY.—Under the pilot program, the Secretary shall  
9           provide for payment under section 1848 of the Social Se-  
10          curity Act (42 U.S.C. 1395w-4) of a per member per  
11          month care coordination fee to primary care providers for  
12          the care of eligible Medicare beneficiaries participating in  
13          the pilot program. The Secretary shall appoint a com-  
14          mittee to make recommendations about the design and im-  
15          plementation of a methodology for payment of the per  
16          member per month care coordination fee.

17          (d) PROVISION OF DATA AND TECHNICAL ASSIST-  
18          ANCE.—The Secretary shall provide—

19               (1) data to primary care providers participating  
20               in the pilot program; and

21               (2) technical assistance to such primary care  
22               providers that do not meet the criteria for the high-  
23               est tier of the pilot program (as defined by the Sec-  
24               retary).

25          (e) REPORTS BY THE SECRETARY.—

1           (1) INTERIM REPORT.—Not later than January  
2           1, 2013, the Secretary shall submit to Congress an  
3           interim report on the pilot program.

4           (2) FINAL REPORT.—Not later than January 1,  
5           2014, the Secretary shall submit to Congress a final  
6           report on the pilot program. Such report shall in-  
7           clude outcome measures reported by the Secretary  
8           under the pilot program, including at least the fol-  
9           lowing:

10                   (A) The total costs to the Medicare pro-  
11                   gram per eligible Medicare beneficiary partici-  
12                   pating in the pilot program.

13                   (B) The performance of primary care pro-  
14                   viders participating in the pilot program with  
15                   regard to—

16                           (i) quality measures developed by the  
17                           Secretary; and

18                           (ii) patient safety indicators developed  
19                           by the Secretary.

20                   (C) The experience of eligible Medicare  
21                   beneficiaries and primary care providers partici-  
22                   pating in the pilot program.

23                   (D) An assessment of savings to the Medi-  
24                   care program per eligible Medicare beneficiary  
25                   participating in the pilot program that are a re-

1           sult of such participation, as compared to tradi-  
 2           tional Medicare fee-for-service payment meth-  
 3           odologies.

4           (f) GAO ASSESSMENT AND REPORT.—

5           (1) ASSESSMENT.—The Comptroller General of  
 6           the United States shall, at the completion of the  
 7           pilot program, provide for an overall assessment of  
 8           the efficacy of the pilot program.

9           (2) REPORT.—Not later than January 1, 2014,  
 10          the Comptroller General shall submit to Congress a  
 11          report containing the results of the assessment  
 12          under paragraph (1).

13   **SEC. 104. IMPROVEMENTS TO PAYMENTS FOR GRADUATE**  
 14                   **MEDICAL EDUCATION UNDER MEDICARE.**

15          (a) INCREASING THE MEDICARE CAPS ON GRADUATE  
 16          MEDICAL EDUCATION POSITIONS.—

17           (1) DIRECT GRADUATE MEDICAL EDUCATION.—

18          Section 1886(h)(4)(F) of the Social Security Act (42  
 19          U.S.C. 1395ww(h)(4)(F)) is amended—

20                   (A) in clause (i), by inserting “clause (iii)  
 21                   and” after “subject to”; and

22                   (B) by adding at the end the following new  
 23                   clause:

24                                   “(iii) INCREASE IN CAPS ON GRAD-  
 25                                   UATE MEDICAL EDUCATION POSITIONS FOR

1 STATES WITH A SHORTAGE OF RESI-  
2 DENTS.—

3 “(I) IN GENERAL.—For cost re-  
4 porting periods beginning on or after  
5 January 1, 2011, the Secretary shall  
6 increase the otherwise applicable limit  
7 on the total number of full-time equiv-  
8 alent residents in the field of  
9 allopathic or osteopathic medicine de-  
10 termined under clause (i) with respect  
11 to a qualifying hospital by an amount  
12 equal to 15 percent of the amount of  
13 the otherwise applicable limit (deter-  
14 mined without regard to this clause).  
15 Such increase shall be phased-in  
16 equally over a period of 3 cost report-  
17 ing periods beginning with the first  
18 cost reporting period in which the in-  
19 crease is applied under the previous  
20 sentence to the hospital.

21 “(II) QUALIFYING HOSPITAL.—  
22 In this clause, the term ‘qualifying  
23 hospital’ means a hospital that agrees  
24 to use the increase in the number of  
25 full-time equivalent residents under

1 subclause (I) to support community-  
2 based training which emphasizes un-  
3 derserved areas and innovative train-  
4 ing models which address community  
5 needs and reflect emerging, evolving,  
6 and contemporary models of health  
7 care delivery. A qualifying hospital  
8 shall give priority to providing such  
9 training and training models to health  
10 professionals in specialties which the  
11 Secretary, in consultation with the  
12 Permanent National Health Work-  
13 force Commission established under  
14 section 101(a) of the Health Access  
15 and Health Professions Supply Act of  
16 2009, determines are in high-need (in-  
17 cluding family medicine, general sur-  
18 gery, geriatrics, general internal medi-  
19 cine, general surgery, and obstetrics  
20 and gynecology).

21 “(III) INCREASE IN PAY-  
22 MENTS.—Notwithstanding any other  
23 provision of law, in the case of full-  
24 time equivalent residents added to a  
25 hospital’s training program as a result

1 of such increase, the Secretary shall  
 2 provide for an increase in the amounts  
 3 otherwise payable under this sub-  
 4 section with respect to direct graduate  
 5 medical education costs that would  
 6 otherwise apply with respect to such  
 7 residents by 10 percent. Such in-  
 8 creased payments shall be made to the  
 9 facility in which the training is pro-  
 10 vided to such residents.”.

11 (2) INDIRECT MEDICAL EDUCATION.—Section  
 12 1886(d)(5)(B) of the Social Security Act (42 U.S.C.  
 13 1395ww(d)(5)(B)) is amended by adding at the end  
 14 the following new clause:

15 “(x) Clause (iii) of subsection (h)(4)(F) shall  
 16 apply to clause (v) in the same manner and for the  
 17 same period as such clause (iii) applies to clause (i)  
 18 of such subsection.”.

19 (b) APPLICATION OF MEDICARE GME PAYMENTS TO  
 20 ADDITIONAL TRAINING SITE VENUES.—

21 (1) IN GENERAL.—The Secretary of Health and  
 22 Human Services (in this subsection referred to as  
 23 the “Secretary”) shall, by regulation, provide for the  
 24 use of payments for direct graduate medical edu-  
 25 cation costs under section 1886(h) of the Social Se-



1 security Act (42 U.S.C. 1395ww(h)) and payments for  
 2 the indirect costs of medical education under section  
 3 1886(d)(5)(B) of the Social Security Act (42 U.S.C.  
 4 1395ww(d)(5)(B)) to support the implementation of  
 5 community-based training and innovative training  
 6 models under subsections (h)(4)(F)(iii)(II) and  
 7 (d)(5)(B)(x) of section 1886 of the Social Security  
 8 Act (42 U.S.C. 1395ww).

9 (2) USE OF MODEL OF CARE DELIVERY.—In  
 10 promulgating regulations under paragraph (1), the  
 11 Secretary shall consider the model of care delivery of  
 12 the Institute of Medicine of the National Academies.

13 (3) CONSULTATION.—In promulgating such  
 14 regulations, the Secretary shall consult with the Per-  
 15 manent National Health Workforce Commission es-  
 16 tablished under section 101(a).

17 (c) DETERMINATION OF HOSPITAL-SPECIFIC AP-  
 18 PROVED FTE RESIDENT AMOUNTS.—Section 1886(h)(2)  
 19 of the Social Security Act (42 U.S.C. 1395ww(h)(2)) is  
 20 amended by adding at the end the following new subpara-  
 21 graph:

22 “(G) FLEXIBILITY IN DETERMINATION.—

23 “(i) IN GENERAL.—Notwithstanding  
 24 the preceding provisions of this paragraph,  
 25 the approved FTE resident amount for

1 each cost reporting period beginning on or  
2 after January 1, 2011, with respect to an  
3 applicable resident shall be determined  
4 using a methodology established by the  
5 Secretary that allows flexibility for pay-  
6 ments to be made for costs in addition to  
7 the costs of hospital-sponsored education.  
8 Such methodology shall provide that non-  
9 teaching hospital-based entities (such as  
10 managed care organizations and public and  
11 private healthcare consortia) that are capa-  
12 ble of assembling all of the resources nec-  
13 essary for effectively providing graduate  
14 medical education may receive payments  
15 for providing graduate medical education,  
16 either as the sponsor of such graduate  
17 medical education program or as an affil-  
18 iate of such a sponsor.

19 “(ii) APPLICABLE RESIDENT.—In this  
20 subparagraph, the term ‘applicable resi-  
21 dent’ means a resident—

22 “(I) in a specialty which the Sec-  
23 retary, in consultation with the Per-  
24 manent National Health Workforce  
25 Commission established under section

1           101(a) of the Health Access and  
 2           Health Professions Supply Act of  
 3           2009, determines is in high-need;

4           “(II) in a health professional  
 5           shortage area (as defined in section  
 6           332 of the Public Health Service Act);

7           “(III) in a medically underserved  
 8           community (as defined in section  
 9           799B of the Public Health Service  
 10          Act), or with respect to a medically  
 11          underserved population (as defined in  
 12          section 330(b)(3) of the Public Health  
 13          Service Act); and

14          “(IV) in a Federal medical facil-  
 15          ity.

16          “(iii) FEDERAL MEDICAL FACILITY.—

17          In this subparagraph, the term ‘Federal  
 18          medical facility’ means a facility for the  
 19          delivery of health services, and includes—

20               “(I) a community health center  
 21               (as defined in section 330 of the Pub-  
 22               lic Health Service Act), a public  
 23               health center, an outpatient medical  
 24               facility, or a community mental health  
 25               center;

1 “(II) a hospital, State mental  
2 hospital, facility for long-term care, or  
3 rehabilitation facility;

4 “(III) a migrant health center or  
5 an Indian Health Service facility;

6 “(IV) a facility for the delivery of  
7 health services to inmates in a penal  
8 or correctional institution (under sec-  
9 tion 323 of such Act) or a State cor-  
10 rectional institution;

11 “(V) a Public Health Service  
12 medical facility (used in connection  
13 with the delivery of health services  
14 under section 320, 321, 322, 324,  
15 325, or 326 of such Act); or

16 “(VI) any other Federal medical  
17 facility.”.

18 **SEC. 105. DISTRIBUTION OF RESIDENT TRAINEES IN AN**  
19 **EMERGENCY.**

20 (a) EXCLUSION FROM 3-YEAR ROLLING AVERAGE.—  
21 Notwithstanding any other provision of law, in the case  
22 of a host hospital participating in an emergency Medicare  
23 GME affiliation agreement on or after the date of enact-  
24 ment of this Act and training residents in excess of its  
25 cap, consistent with the rolling average provisions applica-

1 ble for closed programs as specified in section  
 2 413.79(d)(6) of title 42, Code of Federal Regulations, the  
 3 Secretary of Health and Human Services shall exclude  
 4 from the 3-year rolling average FTE residents associated  
 5 with displaced residents during the period in which such  
 6 agreement is in effect.

7 (b) ASSESSMENT AND REVISION OF GME POLI-  
 8 CIES.—

9 (1) REVIEW.—The Secretary of Health and  
 10 Human Services shall review policies with respect to  
 11 payments for direct graduate medical education  
 12 costs under section 1886(h) of the Social Security  
 13 Act (42 U.S.C. 1395ww(h)) and payments for the  
 14 indirect costs of medical education under section  
 15 1886(d)(5)(B) of the Social Security Act (42 U.S.C.  
 16 1395ww(d)(5)(B)).

17 (2) REVISION AND REPORT.—Not later than  
 18 January 1, 2011, the Secretary shall—

19 (A) as appropriate, revise such policies  
 20 that constrain the ability of the Secretary to re-  
 21 spond to emergency situations and situations  
 22 involving institutional and program closure; and

23 (B) in the case where the Secretary deter-  
 24 mines legislative action is necessary to make  
 25 such revisions, submit to Congress a report con-

1           taining recommendations for such legislative ac-  
 2           tion.

3   **SEC. 106. AUTHORITY TO INCLUDE COSTS OF TRAINING OF**  
 4                   **PSYCHOLOGISTS IN PAYMENTS TO HOS-**  
 5                   **PITALS FOR APPROVED EDUCATIONAL AC-**  
 6                   **TIVITIES UNDER MEDICARE.**

7           Effective for cost reporting periods beginning on or  
 8   after the date that is 18 months after the date of enact-  
 9   ment of this Act, for purposes of payment to hospitals  
 10   under the Medicare program under title XVIII of the So-  
 11   cial Security Act for costs of approved educational activi-  
 12   ties (as defined in section 413.85 of title 42, Code of Fed-  
 13   eral Regulations), such approved educational activities  
 14   shall include a 1-year doctoral clinical internship operated  
 15   by the hospital as part of a clinical psychology training  
 16   program that is provided upon completion of university  
 17   course work.

18   **TITLE II—AMENDMENTS TO THE**  
 19   **PUBLIC HEALTH SERVICE ACT**

20   **SEC. 201. EXPANSION OF NATIONAL HEALTH SERVICE**  
 21                   **CORPS PROGRAMS.**

22           (a) IN GENERAL.—Section 338H of the Public  
 23   Health Service Act (42 U.S.C. 254q) is amended—

24                   (1) in subsection (a), by striking paragraphs  
 25                   (1) through (5) and inserting the following:

1 “(1) for fiscal year 2009, \$165,000,000;  
2 “(2) for fiscal year 2010, \$198,000,000;  
3 “(3) for fiscal year 2011, \$231,000,000;  
4 “(4) for fiscal year 2012, \$264,000,000;  
5 “(5) for fiscal year 2013, \$297,000,000; and  
6 “(6) for fiscal year 2014, \$330,000,000.”; and  
7 (2) by adding at the end the following:

8 “(d) EXPANSION OF PROGRAMS.—The Secretary  
9 shall use amounts appropriated for each of fiscal years  
10 2010 through 2014 under subsection (a), that are in ex-  
11 cess of the amount appropriated under such subsection for  
12 fiscal year 2009, to address shortages of health profes-  
13 sionals in rural, frontier, and urban underserved areas  
14 through an expansion of the number of scholarships and  
15 loan repayments under this subpart to address health  
16 workforce shortages in health professional shortage areas  
17 (as defined in section 332), in medically underserved com-  
18 munities (as defined in section 799B), or with respect to  
19 medically underserved populations (as defined in section  
20 330(b)(3)).”.

21 (b) EXPANSION OF OTHER PROGRAMS.—The Direc-  
22 tor of the Indian Health Service, the Secretary of Defense,  
23 and the Secretary of Veterans Affairs, shall expand exist-  
24 ing loan repayment programs to emphasize the provision

1 of health professions services to facilities that have health  
2 professional shortages.

3 (c) NO TAX IMPLICATIONS.—

4 (1) IN GENERAL.—For purposes of the Internal  
5 Revenue Code of 1986, any amount received under  
6 a health-related Federal loan repayment program by  
7 a health professional providing health-related serv-  
8 ices in a Federal medical facility shall not be in-  
9 cluded in the gross income of such professional.

10 (2) DEFINITION.—In this subsection, the term  
11 “Federal medical facility” means a facility for the  
12 delivery of health services, and includes—

13 (A) a federally qualified health center (as  
14 defined in section 330A of the Public Health  
15 Service Act (42 U.S.C. 254c)), a public health  
16 center, an outpatient medical facility, or a com-  
17 munity mental health center;

18 (B) a hospital, State mental hospital, facil-  
19 ity for long-term care, or rehabilitation facility;

20 (C) a migrant health center or an Indian  
21 Health Service facility;

22 (D) a facility for the delivery of health  
23 services to inmates in a penal or correctional in-  
24 stitution (under section 323 of such Act (42  
25 U.S.C. 250)) or a State correctional institution;



1                   (E) a Public Health Service medical facil-  
 2                   ity (used in connection with the delivery of  
 3                   health services under section 320, 321, 322,  
 4                   324, 325, or 326 of such Act (42 U.S.C. 247e,  
 5                   248, 249, 251, 252, or 253));

6                   (F) a nurse-managed health center; or

7                   (G) any other Federal medical facility.

8           (d) REDUCED LOAN SUPPORT FOR PART TIME  
 9 PRACTITIONERS.—Section 338C of the Public Health  
 10 Service Act (42 U.S.C. 254m) is amended by adding at  
 11 the end the following:

12           “(e) Notwithstanding any other provision of this sub-  
 13 part, the Secretary shall develop procedures to permit pe-  
 14 riods of obligated services to be provided on a part-time  
 15 basis (not less than 1,040 hours of such service per year).  
 16 Such procedures shall prohibit an individual from holding  
 17 other part-time employment while providing such part-  
 18 time obligated services. The Secretary may provide for a  
 19 reduction in the loan repayments provided to individuals  
 20 who provide part-time obligated services under the author-  
 21 ity provided under this subsection.”.

22           (e) LOAN SUPPORT FOR PARTICIPATING PRECEP-  
 23 TORS, MENTORS, AND ATTENDINGS TO SUPERVISE STU-  
 24 DENTS AND TRAINEES ON-SITE.—Section 338C of the  
 25 Public Health Service Act (42 U.S.C. 254m), as amended

1 by subsection (d), is further amended by adding at the  
2 end the following:

3 “(f) The Secretary shall develop procedures to permit  
4 up to 20 percent of the service obligation of an individual  
5 under this section to be provided by the individual through  
6 precepting or mentoring activities, or by preparing cur-  
7 riculum, for on-site students and trainees. The procedures  
8 developed under subsection (e) shall provide for the pro-  
9 portional application of this subsection with respect to in-  
10 dividual providing obligated service on a part-time basis.”.

11 **SEC. 202. NATIONAL HEALTH SERVICE CORPS SCHOLAR-**  
12 **SHIP PROGRAM FOR MEDICAL, DENTAL, PHY-**  
13 **SICIAN ASSISTANT, PHARMACY, BEHAVIORAL**  
14 **AND MENTAL HEALTH, PUBLIC HEALTH, AND**  
15 **NURSING STUDENTS IN THE UNITED STATES**  
16 **PUBLIC HEALTH SCIENCES TRACK IN AFFILI-**  
17 **ATED SCHOOLS.**

18 (a) PROGRAM AUTHORIZED.—

19 (1) IN GENERAL.—Subpart III of part D of  
20 title III of the Public Health Service Act (42 U.S.C.  
21 254l et seq.) is amended—

22 (A) in the heading by inserting “, **Schol-**  
23 **arship Program for Medical, Dental,**  
24 **Physician Assistant, Pharmacy, Be-**  
25 **havioral and Mental Health, Public**

**Health, and Nursing Students in the  
United States Public Health Sciences  
Track in Affiliated Schools,”** after  
**“Scholarship Program”**; and

(B) by inserting after section 338A the fol-  
lowing:

**“SEC. 338A-1. NATIONAL HEALTH SERVICE CORPS SCHOL-  
ARSHIP PROGRAM FOR MEDICAL, DENTAL,  
PHYSICIAN ASSISTANT, PHARMACY, BEHAV-  
IORAL AND MENTAL HEALTH, PUBLIC  
HEALTH, AND NURSING STUDENTS IN THE  
UNITED STATES PUBLIC HEALTH SCIENCES  
TRACK IN AFFILIATED SCHOOLS.**

**“(a) ESTABLISHMENT.—**

**“(1) IN GENERAL.—**The Secretary shall estab-  
lish a program to be known as the National Health  
Service Corps Scholarship Program for Medical,  
Dental, Physician Assistant, Pharmacy, Behavioral  
and Mental Health, Public Health, and Nursing Stu-  
dents in the United States Public Health Sciences  
Track in Affiliated Schools (in this section referred  
to as the ‘U.S. Public Health Sciences Track Schol-  
arship Program’) to ensure, with respect to the pro-  
vision of high-needs health care services, including  
primary care, general dentistry, nursing, obstetrics,

1       and geriatricians pursuant to section 331(a)(2), an  
2       adequate supply of physicians, physician assistants,  
3       pharmacists, behavioral and mental health profes-  
4       sionals, public health professionals, dentists, and  
5       nurses. The purpose of this program is to train an  
6       additional 150 medical students, 100 dental stu-  
7       dents, 100 physician assistant students, 100 behav-  
8       ioral and mental health students, 100 public health  
9       students, and 250 nursing students during each  
10      year. Of the 150 scholarships awarded to the med-  
11      ical students as described under the preceding sen-  
12      tence, 10 shall be for training at the Uniformed  
13      Services University of the Health Sciences as mem-  
14      bers of the Commissioned Corps of the Public  
15      Health Service.

16           “(2) RELATIONSHIP TO NATIONAL HEALTH  
17      SERVICE CORPS SCHOLARSHIP PROGRAM.—Scholar-  
18      ships provided under this section are intended to  
19      complement, and not take the place of, scholarships  
20      provided to students enrolled in courses of study  
21      leading to a degree in medicine, osteopathic medi-  
22      cine, dentistry, or nursing or completion of an ac-  
23      credited physician assistant, pharmacy, public  
24      health, or behavioral and mental health educational

1       program under the National Health Service Corps  
2       Scholarship Program authorized by section 338A.

3       “(b) ELIGIBILITY.—To be eligible to participate in  
4 the U.S. Public Health Sciences Track Scholarship and  
5 Grants Program, an individual shall—

6               “(1) be accepted for enrollment as a full-time  
7       student—

8                       “(A) in an accredited (as determined by  
9       the Secretary) educational institution in a  
10       State; and

11                      “(B) in a course of study, or program, of-  
12       fered by such institution leading to a degree in  
13       medicine, osteopathic medicine, dentistry, physi-  
14       cian assistant, pharmacy, behavioral and mental  
15       health, public health, or nursing;

16               “(2) be eligible for, or hold, an appointment as  
17       a commissioned officer in the Regular or Reserve  
18       Corps of the Service or be eligible for selection for  
19       civilian service in the Corps;

20               “(3) submit an application to participate in the  
21       U.S. Public Health Sciences Track Scholarship and  
22       Grants Program; and

23               “(4) sign and submit to the Secretary, at the  
24       time of submittal of such application, a written con-  
25       tract to accept payment of a scholarship and to

1       serve (in accordance with this subpart) for the appli-  
 2       cable period of obligated service in an area in which  
 3       the need for public health-related services may be  
 4       demonstrated.”.

5           (2) NO TAX IMPLICATIONS.—For purposes of  
 6       the Internal Revenue Code of 1986, any amount re-  
 7       ceived under the National Health Service Corps  
 8       Scholarship Program for Medical, Dental and Nurs-  
 9       ing Students in the United States Public Health  
 10      Sciences Track in Affiliated Schools under section  
 11      338A–1 of the Public Health Service Act, as added  
 12      by paragraph (1), by a medical student, dental stu-  
 13      dent, or nursing student shall not be included in the  
 14      gross income of such student.

15      (b) GRANTS TO INCREASE THE NUMBER OF AVAIL-  
 16      ABLE SLOTS FOR NEWLY ADMITTED MEDICAL, DENTAL,  
 17      PHYSICIAN ASSISTANT, PHARMACY, BEHAVIORAL AND  
 18      MENTAL HEALTH, PUBLIC HEALTH, AND NURSING STU-  
 19      DENTS AND TO INCREASE PARTICIPATION IN THE U.S.  
 20      PUBLIC HEALTH SCIENCES TRACK SCHOLARSHIP PRO-  
 21      GRAM.—Part C of title VII of the Public Health Service  
 22      Act (42 U.S.C. 293k et seq.) is amended by adding at  
 23      the end the following:

1 **“SEC. 749. GRANTS TO INCREASE THE NUMBER OF AVAIL-**  
2 **ABLE SLOTS FOR NEWLY ADMITTED MED-**  
3 **ICAL, DENTAL, PHYSICIAN ASSISTANT, PHAR-**  
4 **MACY, BEHAVIORAL AND MENTAL HEALTH,**  
5 **PUBLIC HEALTH, AND NURSING STUDENTS**  
6 **AND TO INCREASE PARTICIPATION IN THE**  
7 **U.S. PUBLIC HEALTH SCIENCES TRACK**  
8 **SCHOLARSHIP PROGRAM.**

9 “(a) PROGRAM AUTHORIZED.—The Secretary may  
10 make grants to medical, dental, public health, and nursing  
11 schools and physician assistant, pharmacy, and behavioral  
12 and mental health programs for the following purposes:

13 “(1) To increase the capacity of the recipient  
14 medical, dental, public health, or nursing school or  
15 physician assistant, pharmacy, or behavioral and  
16 mental health program, to accept additional medical,  
17 dental, public health, nursing, physician assistant,  
18 pharmacy, or behavioral and mental health students  
19 each year.

20 “(2) To develop curriculum.

21 “(3) To acquire equipment.

22 “(4) To recruit, train, and retain faculty.

23 “(5) To provide assistance to students who have  
24 completed a course of study at the recipient medical,  
25 dental, public health, or nursing school or physician  
26 assistant, pharmacy, or behavioral and mental health

1       program during the period in which such students  
 2       are completing a residency or internship program af-  
 3       filiated with the recipient institution.

4       “(b) APPLICATION.—A medical, dental, public health,  
 5       or nursing school or physician assistant, pharmacy, or be-  
 6       havioral and mental health program seeking a grant under  
 7       this section shall submit an application to the Secretary  
 8       at such time, in such manner, and containing such infor-  
 9       mation as the Secretary may require.

10       “(c) DEFINITION OF MEDICAL SCHOOL.—In this sec-  
 11       tion, the term ‘medical school’ means a school of medicine  
 12       or a school of osteopathic medicine.”.

13       **SEC. 203. FEDERAL MEDICAL FACILITY GRANT PROGRAM**  
 14               **AND PROGRAM ASSESSMENTS.**

15       (a) FEDERAL MEDICAL FACILITY GRANT PRO-  
 16       GRAM.—Title VII of the Public Health Service Act (42  
 17       U.S.C. 292 et seq.) is amended—

18               (1) by redesignating part F as part G; and

19               (2) by inserting after part E, the following:



1 **“PART F—START-UP EXPENSES LOAN AND GRANT**  
 2 **PROGRAMS FOR FEDERAL MEDICAL FACILI-**  
 3 **TIES AND HOSPITALS STARTING HIGH**  
 4 **NEEDS RESIDENCY PROGRAMS IN SHORT-**  
 5 **AGE AREAS**

6 **“SEC. 781. FEDERAL MEDICAL FACILITY GRANT PROGRAM.**

7 “(a) IN GENERAL.—The Secretary shall award  
 8 grants to eligible facilities to increase interdisciplinary,  
 9 community-based health professions training in high-needs  
 10 specialties for physicians, nurses, dentists, physician as-  
 11 sistants, pharmacy, behavioral and mental health profes-  
 12 sionals, public health professionals, and other health pro-  
 13 fessionals as determined appropriate by the Secretary, in  
 14 consultation with the Permanent National Health Work-  
 15 force Commission established under section 101(a) of the  
 16 Health Access and Health Professions Supply Act of  
 17 2009.

18 “(b) ELIGIBLE FACILITIES; APPLICATION.—

19 “(1) DEFINITION OF ELIGIBLE FACILITY.—In  
 20 this section, the term ‘eligible facility’—

21 “(A) means a facility which—

22 “(i) is located in a health professional  
 23 shortage area (as defined in section 332);

24 “(ii) is located in a medically under-  
 25 served community (as defined in section  
 26 799B), or with respect to a medically un-

derserved population (as defined in section  
330(b)(3));

“(iii) is a Federal medical facility;

“(iv) is an area health education center, a health education and training center, or a participant in the Quentin N. Burdick program for rural interdisciplinary training, that meet the requirements established by the Secretary; or

“(v) is establishing new residency programs in a specialty which the Secretary, in consultation with the Permanent National Health Workforce Commission established under section 101(a) of the Health Access and Health Professions Supply Act of 2009, determines is in high-need; and

“(B) includes Medicare certified Federally Qualified Health Centers, community health centers, health care for the homeless centers, rural health centers, migrant health centers, Indian Health Service entities, urban Indian centers, health clinics and hospitals operated by the Indian Health Service, Indian tribes and tribal organizations, and urban Indian organi-

1           zations (as defined in section 4 of the Indian  
2           Health Care Improvement Act), and other Fed-  
3           eral medical facilities).

4           “(2) APPLICATION.—An eligible facility desiring  
5           a grant under subsection (a) shall submit to the Sec-  
6           retary an application at such time, in such manner,  
7           and containing such information as the Secretary  
8           may require.

9           “(c) USE OF FUNDS.—An eligible facility shall use  
10          amounts received under a grant under subsection (a) to  
11          promote—

12           “(1) the training of health professionals in  
13           interdisciplinary, community-based settings that are  
14           affiliated with hospitals and other health care facili-  
15           ties and teaching institutions;

16           “(2) community development programs that as-  
17           sure a diverse health professions workforce through  
18           emphasis on individuals from rural and frontier  
19           areas and underrepresented minority groups;

20           “(3) the development of a reliable health profes-  
21           sions pipeline that provides an emphasis on health-  
22           related careers in schools (such as schools partici-  
23           pating in the Health Careers Opportunities Pro-  
24           gram) and centers of excellence, and that encourage  
25           individuals in underrepresented minorities (including

1 Hispanic, African-American, American Indian, and  
2 Alaska Native individuals) to pursue health profes-  
3 sions careers;

4 “(4) the reduction of health professional isola-  
5 tion in rural, frontier, and urban underserved areas  
6 through the provision of continuing education, men-  
7 toring, and precepting activities, field faculty devel-  
8 opment, and the utilization of technology such as  
9 telehealth and electronic health records;

10 “(5) the establishment and operation of re-  
11 gional or statewide health advice telephone lines to  
12 reduce after-hours call responsibilities for over-  
13 worked health professionals who provide services in  
14 remote areas that have few health professionals tak-  
15 ing such after-hours calls;

16 “(6) an increase in the number of professionals  
17 taking after-hours calls in hospitals and emergency  
18 departments in health professional shortage areas  
19 (as defined in section 332), in medically underserved  
20 communities (as defined in section 799B), or with  
21 respect to medically underserved populations (as de-  
22 fined in section 330(b)(3));

23 “(7) the establishment and operation of relief  
24 programs that provide health professionals prac-  
25 ticing in health professional shortage areas (as de-

1       fined in section 332) with patient and call coverage  
 2       when such professionals are ill, are pursuing con-  
 3       tinuing education, or are taking a vacation; and

4           “(8) the exposure of health professions resi-  
 5       dents to systems of health care that represent the  
 6       contemporary American healthcare delivery program  
 7       (such as ‘P4’ Prepare the Personal Physician for  
 8       Practice and the ‘Health Commons’ programs).

9       “(d) SUBGRANTS.—An eligible facility may use  
 10      amounts received under a grant under this section to  
 11      award subgrants to States and other entities determined  
 12      appropriate by the Secretary to carry out the activities de-  
 13      scribed in subsection (c).

14       “(e) SET ASIDE.—In awarding grants under this sec-  
 15      tion, the Secretary shall ensure that a total of \$500,000  
 16      is awarded annually for the activities of the National  
 17      Rural Recruitment and Retention Network, or a similar  
 18      entity.

19       “(f) DEFINITION OF FEDERAL MEDICAL FACIL-  
 20      ITY.—In this section, the term ‘Federal medical facility’  
 21      means a facility for the delivery of health services, and  
 22      includes—

23           “(1) a federally qualified health center (as de-  
 24      fined in section 330A), a public health center, an

1 outpatient medical facility, or a community mental  
2 health center;

3 “(2) a hospital, State mental hospital, facility  
4 for long-term care, or rehabilitation facility;

5 “(3) a migrant health center or an Indian  
6 Health Service facility;

7 “(4) a facility for the delivery of health services  
8 to inmates in a penal or correctional institution  
9 (under section 323) or a State correctional institu-  
10 tion;

11 “(5) a Public Health Service medical facility  
12 (used in connection with the delivery of health serv-  
13 ices under section 320, 321, 322, 324, 325, or  
14 326)); or

15 “(6) any other Federal medical facility.

16 “(g) AUTHORIZATION OF APPROPRIATIONS.—There  
17 are authorized to be appropriated to carry out this section,  
18 \$623,000,000 for fiscal year 2009, \$666,000,000 for fis-  
19 cal year 2010, \$675,000,000 for fiscal year 2011,  
20 \$700,000,000 for fiscal year 2012, and \$725,000,000 for  
21 fiscal year 2013.”.

22 (b) ASSESSMENTS.—

23 (1) ESTABLISHMENT.—The Secretary of Health  
24 and Human Services (referred to in this section as  
25 the “Secretary”) shall establish program assessment

1 rating tools for each program funded through titles  
 2 VII and VIII of the Public Health Service Act (42  
 3 U.S.C. 292 and 296 et seq.).

4 (2) CRITERIA.—The Secretary, in consultation  
 5 with the Administrator of the Health Resources and  
 6 Services Administration and other appropriate public  
 7 and private stakeholders, shall, through negotiated  
 8 rulemaking, establish criteria for the conduct of the  
 9 assessments under paragraph (2).

10 (3) ANNUAL ASSESSMENTS.—The Secretary  
 11 shall annually enter into a contract with an inde-  
 12 pendent nongovernmental entity for the conduct of  
 13 an assessment, using the tools established under  
 14 paragraph (1) and the criteria established under  
 15 paragraph (2), of not less than 20 percent, nor more  
 16 than 25 percent, of the programs carried out under  
 17 titles VII and VIII of the Public Health Service Act,  
 18 so that every program under such titles is assessed  
 19 at least once during every 5-year period.

20 **SEC. 204. HEALTH PROFESSIONS TRAINING LOAN PRO-**  
 21 **GRAM.**

22 Part F of title VII of the Public Health Service Act  
 23 (as added by section 203) is amended by adding at the  
 24 end the following:

1 **“SEC. 782. ESTABLISHMENT.**

2 “(a) IN GENERAL.—The Secretary shall establish a  
3 program under which the Secretary shall award interest-  
4 free loans to—

5 “(1) eligible hospitals to enable such hospitals  
6 to establish training programs in high-need special-  
7 ties; and

8 “(2) eligible non-hospital community-based enti-  
9 ties to enable such entities to establish health profes-  
10 sions training programs.

11 “(b) ELIGIBILITY.—

12 “(1) IN GENERAL.—To be eligible to receive a  
13 loan under subsection (a)—

14 “(A) a hospital shall—

15 “(i) be located in a health professional  
16 shortage area (as such term is defined in  
17 section 332);

18 “(ii) comply with the requirements of  
19 paragraph (2); and

20 “(iii) submit to the Secretary an ap-  
21 plication at such time, in such manner,  
22 and containing such information as the  
23 Secretary may require; or

24 “(B) a non-hospital community-based enti-  
25 ty shall—



1 “(i) comply with the requirements of  
2 paragraph (2); and

3 “(ii) submit to the Secretary an appli-  
4 cation at such time, in such manner, and  
5 containing such information as the Sec-  
6 retary may require.

7 “(2) REQUIREMENTS.—To be eligible to receive  
8 a loan under subsection (a), a hospital or non-hos-  
9 pital community-based entity shall—

10 “(A) on the date on which the entity sub-  
11 mits the loan application, not operate a resi-  
12 dency with respect to a high-needs specialty (as  
13 determined by the Secretary in consultation  
14 with the Permanent National Health Workforce  
15 Commission established under section 101(a) of  
16 the Health Access and Health Professions Sup-  
17 ply Act of 2009) or provide a health professions  
18 training program, as the case may be;

19 “(B) have received appropriate preliminary  
20 accreditation from the relevant accrediting  
21 agency (American Council for Graduate Medical  
22 Education, American Osteopathic Association,  
23 or Dental, Physician Assistant, Pharmacy, Be-  
24 havioral and Mental Health, Public Health, and

1           Nursing accrediting agencies), as determined by  
2           the Secretary; and

3           “(C) execute a signed formal contract  
4           under which the hospital or entity agree to  
5           repay the loan.

6           “(c) USE OF LOAN FUNDS.—Amounts received under  
7           a loan under subsection (a) shall be used only for—

8           “(1) the salary and fringe benefit expenses of  
9           residents, students, trainees, and faculty, or other  
10          costs directly attributable to the residency, edu-  
11          cational, or training program to be carried out under  
12          the loan, as specified by the Secretary; or

13          “(2) facility construction or renovation, includ-  
14          ing equipment purchase.

15          “(d) PRIORITY.—In awarding loans under subsection  
16          (a), the Secretary shall give priority to applicants that are  
17          located in health professional shortage areas (as defined  
18          in section 332) or in medically underserved communities  
19          (as defined in section 799B), or that serve medically un-  
20          derserved populations (as defined in section 330(b)(3)).

21          “(e) LOAN PROVISIONS.—

22          “(1) LOAN CONTRACT.—The loan contract en-  
23          tered into under subsection (b)(2) shall contain  
24          terms that provide for the repayment of the loan, in-  
25          cluding the number and amount of installment pay-

1       ments as described in such contract. Such repay-  
 2       ment shall begin on the date that is 24 months after  
 3       the date on which the loan contract is executed and  
 4       shall be fully repaid not later than 36 months after  
 5       the date of the first payment.

6               “(2) INTEREST.—Loans under this section shall  
 7       be repaid without interest.

8               “(f) LIMITATION.—The amount of a loan under this  
 9       section with respect to each of the uses described in sub-  
 10      section (c)(1) or (c)(2) shall not exceed \$2,000,000.

11              “(g) FAILURE TO REPAY.—A hospital or non-hos-  
 12      pital community-based entity that fails to comply with the  
 13      terms of a contract entered into under subsection (b)(2)  
 14      shall be liable to the United States for the amount which  
 15      has been paid to such hospital or entity under the con-  
 16      tract.

17              “(h) AUTHORIZATION OF APPROPRIATIONS.—There  
 18      is authorized to be appropriated, such sums as may be  
 19      necessary to carry out this section.”.

20      **SEC. 205. UNITED STATES PUBLIC HEALTH SCIENCES**  
 21                              **TRACK.**

22              Title II of the Public Health Service Act (42 U.S.C.  
 23      202 et seq.) is amended by adding at the end the fol-  
 24      lowing:

**“PART D—UNITED STATES PUBLIC HEALTH  
SCIENCES TRACK**

**“SEC. 271. ESTABLISHMENT.**

“(a) UNITED STATES PUBLIC HEALTH SERVICES  
TRACK.—

“(1) IN GENERAL.—There is hereby authorized  
to be established a United States Public Health  
Sciences Track (referred to in this part as the  
‘Track’), at sites to be selected by the Secretary,  
with authority to grant appropriate advanced de-  
grees in a manner that uniquely emphasizes team-  
based service, public health, epidemiology, and emer-  
gency preparedness and response. It shall be so or-  
ganized as to graduate not less than—

“(A) 150 medical students annually;

“(B) 100 dental students annually;

“(C) 250 nursing students annually;

“(D) 100 public health students annually;

“(E) 100 behavioral and mental health  
professional students annually;

“(F) 100 physician assistant or nurse  
practitioner students annually; and

“(G) 50 pharmacy students annually.

“(2) LOCATIONS.—The Track shall be located  
at existing and accredited, affiliated health profes-  
sions education training programs at academic

1 health centers located in regions of the United  
2 States determined appropriate by the Surgeon Gen-  
3 eral, in consultation with the Permanent National  
4 Health Workforce Commission.

5 “(b) NUMBER OF GRADUATES.—Except as provided  
6 in subsection (a), the number of persons to be graduated  
7 from the Track shall be prescribed by the Secretary. In  
8 so prescribing the number of persons to be graduated from  
9 the Track, the Secretary shall institute actions necessary  
10 to ensure the maximum number of first-year enrollments  
11 in the Track consistent with the academic capacity of the  
12 affiliated sites and the needs of the United States for med-  
13 ical, dental, and nursing personnel.

14 “(c) DEVELOPMENT.—The development of the Track  
15 may be by such phases as the Secretary may prescribe  
16 subject to the requirements of subsection (a).

17 “(d) INTEGRATED LONGITUDINAL PLAN.—The Sur-  
18 geon General shall develop an integrated longitudinal plan  
19 for health professions continuing education throughout the  
20 continuum of health-related education, training, and prac-  
21 tice. Training under such plan shall emphasize patient-  
22 centered, interdisciplinary, and care coordination skills.  
23 Experience with deployment of emergency response teams  
24 shall be included during the clinical experiences.

1       “(e) FACULTY DEVELOPMENT.—The Surgeon Gen-  
 2 eral shall develop faculty development programs and cur-  
 3 ricula in decentralized venues of health care, to balance  
 4 urban, tertiary, and inpatient venues.

5       **“SEC. 272. ADMINISTRATION.**

6       “(a) IN GENERAL.—The business of the Track shall  
 7 be conducted by the Surgeon General with funds appro-  
 8 priated for and provided by the Department of Health and  
 9 Human Services. The Permanent National Health Work-  
 10 force Commission shall assist the Surgeon General in an  
 11 advisory capacity.

12       “(b) FACULTY.—

13               “(1) IN GENERAL.—The Surgeon General, after  
 14 considering the recommendations of the Permanent  
 15 National Health Workforce Commission, shall obtain  
 16 the services of such professors, instructors, and ad-  
 17 ministrative and other employees as may be nec-  
 18 essary to operate the Track, but utilize when pos-  
 19 sible, existing affiliated health professions training  
 20 institutions. Members of the faculty and staff shall  
 21 be employed under salary schedules and granted re-  
 22 tirement and other related benefits prescribed by the  
 23 Secretary so as to place the employees of the Track  
 24 faculty on a comparable basis with the employees of

1 fully accredited schools of the health professions  
2 within the United States.

3 “(2) TITLES.—The Surgeon General may con-  
4 fer academic titles, as appropriate, upon the mem-  
5 bers of the faculty.

6 “(3) NONAPPLICATION OF PROVISIONS.—The  
7 limitations in section 5373 of title 5, United States  
8 Code, shall not apply to the authority of the Surgeon  
9 General under paragraph (1) to prescribe salary  
10 schedules and other related benefits.

11 “(c) AGREEMENTS.—The Surgeon General may ne-  
12 gotiate agreements with agencies of the Federal Govern-  
13 ment to utilize on a reimbursable basis appropriate exist-  
14 ing Federal medical resources located in the United States  
15 (or locations selected in accordance with section  
16 271(a)(2)). Under such agreements the facilities con-  
17 cerned will retain their identities and basic missions. The  
18 Surgeon General may negotiate affiliation agreements  
19 with accredited universities and health professions train-  
20 ing institutions in the United States. Such agreements  
21 may include provisions for payments for educational serv-  
22 ices provided students participating in Department of  
23 Health and Human Services educational programs.

1       “(d) PROGRAMS.—The Surgeon General may estab-  
 2       lish the following educational programs for Track stu-  
 3       dents:

4               “(1) Postdoctoral, postgraduate, and techno-  
 5       logical institutes.

6               “(2) A graduate school of nursing.

7               “(3) Other schools or programs that the Sur-  
 8       geon General determines necessary in order to oper-  
 9       ate the Track in a cost-effective manner.

10       “(e) CONTINUING MEDICAL EDUCATION.—The Sur-  
 11       geon General shall establish programs in continuing med-  
 12       ical education for members of the health professions to  
 13       the end that high standards of health care may be main-  
 14       tained within the United States.

15       “(f) AUTHORITY OF THE SURGEON GENERAL.—

16               “(1) IN GENERAL.—The Surgeon General is au-  
 17       thorized—

18                       “(A) to enter into contracts with, accept  
 19       grants from, and make grants to any nonprofit  
 20       entity for the purpose of carrying out coopera-  
 21       tive enterprises in medical, dental, physician as-  
 22       sistant, pharmacy, behavioral and mental  
 23       health, public health, and nursing research,  
 24       consultation, and education;



1           “(B) to enter into contracts with entities  
2           under which the Surgeon General may furnish  
3           the services of such professional, technical, or  
4           clerical personnel as may be necessary to fulfill  
5           cooperative enterprises undertaken by the  
6           Track;

7           “(C) to accept, hold, administer, invest,  
8           and spend any gift, devise, or bequest of per-  
9           sonal property made to the Track, including  
10          any gift, devise, or bequest for the support of  
11          an academic chair, teaching, research, or dem-  
12          onstration project;

13          “(D) to enter into agreements with entities  
14          that may be utilized by the Track for the pur-  
15          pose of enhancing the activities of the Track in  
16          education, research, and technological applica-  
17          tions of knowledge; and

18          “(E) to accept the voluntary services of  
19          guest scholars and other persons.

20          “(2) LIMITATION.—The Surgeon General may  
21          not enter into any contract with an entity if the con-  
22          tract would obligate the Track to make outlays in  
23          advance of the enactment of budget authority for  
24          such outlays.

1           “(3) SCIENTISTS.—Scientists or other medical,  
 2           dental, or nursing personnel utilized by the Track  
 3           under an agreement described in paragraph (1) may  
 4           be appointed to any position within the Track and  
 5           may be permitted to perform such duties within the  
 6           Track as the Surgeon General may approve.

7           “(4) VOLUNTEER SERVICES.—A person who  
 8           provides voluntary services under the authority of  
 9           subparagraph (E) of paragraph (1) shall be consid-  
 10          ered to be an employee of the Federal Government  
 11          for the purposes of chapter 81 of title 5, relating to  
 12          compensation for work-related injuries, and to be an  
 13          employee of the Federal Government for the pur-  
 14          poses of chapter 171 of title 28, relating to tort  
 15          claims. Such a person who is not otherwise employed  
 16          by the Federal Government shall not be considered  
 17          to be a Federal employee for any other purpose by  
 18          reason of the provision of such services.

19 **“SEC. 273. STUDENTS; SELECTION; OBLIGATION.**

20           “(a) STUDENT SELECTION.—

21           “(1) IN GENERAL.—Medical, dental, physician  
 22           assistant, pharmacy, behavioral and mental health,  
 23           public health, and nursing students at the Track  
 24           shall be selected under procedures prescribed by the  
 25           Surgeon General. In so prescribing, the Surgeon

1 General shall consider the recommendations of the  
 2 Permanent National Health Workforce Commission.

3 “(2) PRIORITY.—In developing admissions pro-  
 4 cedures under paragraph (1), the Surgeon General  
 5 shall ensure that such procedures give priority to ap-  
 6 plicant medical, dental, physician assistant, phar-  
 7 macy, behavioral and mental health, public health,  
 8 and nursing students from rural communities and  
 9 underrepresented minorities.

10 “(b) CONTRACT AND SERVICE OBLIGATION.—

11 “(1) CONTRACT.—Upon being admitted to the  
 12 Track, a medical, dental, physician assistant, phar-  
 13 macy, behavioral and mental health, public health,  
 14 or nursing student shall enter into a written con-  
 15 tract with the Surgeon General that shall contain—

16 “(A) an agreement under which—

17 “(i) subject to subparagraph (B), the  
 18 Surgeon General agrees to provide the stu-  
 19 dent with tuition (or tuition remission) and  
 20 a student stipend (described in paragraph  
 21 (2)) in each school year for a period of  
 22 years (not to exceed 4 school years) deter-  
 23 mined by the student, during which period  
 24 the student is enrolled in the Track at an  
 25 affiliated or other participating health pro-

1           fessions institution pursuant to an agree-  
2           ment between the Track and such institu-  
3           tion; and

4           “(ii) subject to subparagraph (B), the  
5           student agrees—

6                   “(I) to accept the provision of  
7                   such tuition and student stipend to  
8                   the student;

9                   “(II) to maintain enrollment at  
10                  the Track until the student completes  
11                  the course of study involved;

12                  “(III) while enrolled in such  
13                  course of study, to maintain an ac-  
14                  ceptable level of academic standing  
15                  (as determined by the Surgeon Gen-  
16                  eral);

17                  “(IV) if pursuing a degree from  
18                  a school of medicine or osteopathic  
19                  medicine, dental, public health, or  
20                  nursing school or a physician assist-  
21                  ant, pharmacy, or behavioral and  
22                  mental health professional program,  
23                  to complete a residency or internship  
24                  in a specialty that the Surgeon Gen-  
25                  eral determines is appropriate; and

1 “(V) to serve for a period of time  
 2 (referred to in this part as the ‘period  
 3 of obligated service’) within the Com-  
 4 missioned Corps of the Public Health  
 5 Service equal to 2 years for each  
 6 school year during which such indi-  
 7 vidual was enrolled at the College, re-  
 8 duced as provided for in paragraph  
 9 (3);

10 “(B) a provision that any financial obliga-  
 11 tion of the United States arising out of a con-  
 12 tract entered into under this part and any obli-  
 13 gation of the student which is conditioned  
 14 thereon, is contingent upon funds being appro-  
 15 priated to carry out this part;

16 “(C) a statement of the damages to which  
 17 the United States is entitled for the student’s  
 18 breach of the contract; and

19 “(D) such other statements of the rights  
 20 and liabilities of the Secretary and of the indi-  
 21 vidual, not inconsistent with the provisions of  
 22 this part.

23 “(2) TUITION AND STUDENT STIPEND.—

24 “(A) TUITION REMISSION RATES.—The  
 25 Surgeon General, based on the recommenda-

1           tions of the Permanent National Health Work-  
 2           force Commission established under section  
 3           101(a) of the Health Access and Health Profes-  
 4           sions Supply Act of 2009, shall establish Fed-  
 5           eral tuition remission rates to be used by the  
 6           Track to provide reimbursement to affiliated  
 7           and other participating health professions insti-  
 8           tutions for the cost of educational services pro-  
 9           vided by such institutions to Track students.  
 10          The agreement entered into by such partici-  
 11          pating institutions under paragraph (1)(A)(i)  
 12          shall contain an agreement to accept as pay-  
 13          ment in full the established remission rate  
 14          under this subparagraph.

15               “(B) STIPEND.—The Surgeon General,  
 16               based on the recommendations of the Perma-  
 17               nent National Health Workforce Commission,  
 18               shall establish and update Federal stipend rates  
 19               for payment to students under this part.

20               “(3) REDUCTIONS IN THE PERIOD OF OBLI-  
 21               GATED SERVICE.—The period of obligated service  
 22               under paragraph (1)(A)(ii)(V) shall be reduced—

23                       “(A) in the case of a student who elects to  
 24                       participate in a high-needs speciality residency  
 25                       (as determined by the Permanent National

1 Health Workforce Commission), by 3 months  
 2 for each year of such participation (not to ex-  
 3 ceed a total of 12 months); and

4 “(B) in the case of a student who, upon  
 5 completion of their residency, elects to practice  
 6 in a Federal medical facility (as defined in sec-  
 7 tion 781(e)) that is located in a health profes-  
 8 sional shortage area (as defined in section 332),  
 9 by 3 months for year of full-time practice in  
 10 such a facility (not to exceed a total of 12  
 11 months).

12 “(c) SECOND 2 YEARS OF SERVICE.—During the  
 13 third and fourth years in which a medical, dental, physi-  
 14 cian assistant, pharmacy, behavioral and mental health,  
 15 public health, or nursing student is enrolled in the Track,  
 16 training should be designed to prioritize clinical rotations  
 17 in Federal medical facilities in health professional short-  
 18 age areas, and emphasize a balance of hospital and com-  
 19 munity-based experiences, and training within inter-  
 20 disciplinary teams.

21 “(d) DENTIST, PHYSICIAN ASSISTANT, PHARMACIST,  
 22 BEHAVIORAL AND MENTAL HEALTH PROFESSIONAL,  
 23 PUBLIC HEALTH PROFESSIONAL, AND NURSE TRAIN-  
 24 ING.—The Surgeon General shall establish provisions ap-  
 25 plicable with respect to dental, physician assistant, phar-

1 macy, behavioral and mental health, public health, and  
 2 nursing students that are comparable to those for medical  
 3 students under this section, including service obligations,  
 4 tuition support, and stipend support. The Surgeon Gen-  
 5 eral shall give priority to health professions training insti-  
 6 tutions that train medical, dental, physician assistant,  
 7 pharmacy, behavioral and mental health, public health,  
 8 and nursing students for some significant period of time  
 9 together, but at a minimum have a discrete and shared  
 10 core curriculum.

11       “(e) ELITE FEDERAL DISASTER TEAMS.—The Sur-  
 12 geon General, in consultation with the Secretary, the Di-  
 13 rector of the Centers for Disease Control and Prevention,  
 14 and other appropriate military and Federal government  
 15 agencies, shall develop criteria for the appointment of  
 16 highly qualified Track faculty, medical, dental, physician  
 17 assistant, pharmacy, behavioral and mental health, public  
 18 health, and nursing students, and graduates to elite Fed-  
 19 eral disaster preparedness teams to train and to respond  
 20 to public health emergencies, natural disasters, bioter-  
 21 rorism events, and other emergencies.

22       “(f) STUDENT DROPPED FROM TRACK IN AFFILIATE  
 23 SCHOOL.—A medical, dental, physician assistant, phar-  
 24 macy, behavioral and mental health, public health, or  
 25 nursing student who, under regulations prescribed by the



1 Surgeon General, is dropped from the Track in an affili-  
 2 ated school for deficiency in conduct or studies, or for  
 3 other reasons, shall be liable to the United States for all  
 4 tuition and stipend support provided to the student.

5 **“SEC. 274. AUTHORIZATION OF APPROPRIATIONS.**

6 “There is authorized to be appropriated to carry out  
 7 this part, section 338A–1, and section 749, such sums as  
 8 may be necessary.”.

9 **SEC. 206. MEDICAL EDUCATION DEBT REIMBURSEMENT**  
 10 **FOR PHYSICIANS OF THE VETERANS HEALTH**  
 11 **ADMINISTRATION.**

12 (a) IN GENERAL.—The Secretary of Veterans Affairs  
 13 shall carry out a program under which eligible physicians  
 14 described in subsection (b) are reimbursed for the edu-  
 15 cation debt of such physicians as described in subsection  
 16 (c).

17 (b) ELIGIBLE PHYSICIANS.—An eligible physician de-  
 18 scribed in this subsection is any physician currently ap-  
 19 pointed to a physician position in the Veterans Health Ad-  
 20 ministration under section 7402(b)(1) of title 38, United  
 21 States Code, who enters into an agreement with the Sec-  
 22 retary to continue serving as a physician in such position  
 23 for such period of time as the Secretary shall specify in  
 24 the agreement.

1       (c) COVERED EDUCATION DEBT.—The education  
2 debt for which an eligible physician may be reimbursed  
3 under this section is any amount paid by the physician  
4 for tuition, room and board, or expenses in obtaining the  
5 degree of doctor of medicine or of doctor of osteopathy,  
6 including any amounts of principal or interest paid by the  
7 physician under a loan, the proceeds of which were used  
8 by or on behalf of the physician for the costs of obtaining  
9 such degree.

10       (d) FREQUENCY OF REIMBURSEMENT.—Any reim-  
11 bursement of an eligible physician under this section shall  
12 be made in a lump sum or in installments of such fre-  
13 quency as the Secretary shall specify the agreement of the  
14 physician as required under subsection (b).

15       (e) LIABILITY FOR FAILURE TO COMPLETE OBLI-  
16 GATED SERVICE.—Any eligible physician who fails to sat-  
17 isfactorily complete the period of service agreed to by the  
18 physician under subsection (b) shall be liable to the United  
19 States in an amount determined in accordance with the  
20 provisions of section 7617(c)(1) of title 38, United States  
21 Code.

22       (f) TREATMENT OF REIMBURSEMENT WITH OTHER  
23 PAY AND BENEFIT AUTHORITIES.—Any amount of reim-  
24 bursement payable to an eligible physician under this sec-  
25 tion is in addition to any other pay, allowances, or benefits

1 that may be provided the physician under law, including  
 2 any educational assistance under the Department of Vet-  
 3 erans Affairs Health Professional Educational Assistance  
 4 Program under chapter 76 of title 38, United States Code.

5 **TITLE III—HEALTH PROFESSIONAL TRAINING PIPELINE**  
 6 **PARTNERSHIPS PROGRAM**

8 **SEC. 301. GRANTS TO PREPARE STUDENTS FOR CAREERS**  
 9 **IN HEALTH CARE.**

10 (a) PURPOSE.—The purpose of this section is to sup-  
 11 port the development and implementation of programs de-  
 12 signed to prepare middle school and high school students  
 13 for study and careers in the healthcare field, including  
 14 success in postsecondary mathematics and science pro-  
 15 grams.

16 (b) DEFINITIONS.—In this section:

17 (1) CHILDREN FROM LOW-INCOME FAMILIES.—  
 18 The term “children from low-income families”  
 19 means children described in section 1124(c)(1)(A) of  
 20 the Elementary and Secondary Education Act of  
 21 1965 (20 U.S.C. 6333(c)(1)(A)).

22 (2) ELIGIBLE RECIPIENTS.—The term “eligible  
 23 recipient” means—

24 (A) a nonprofit healthcare career pathway  
 25 partnership organization; or

(B) a high-need local educational agency in partnership with—

(i) not less than 1 institution of higher education with an established health profession education program; and

(ii) not less than 1 community-based, private sector healthcare provider organization.

(3) HIGH-NEED LOCAL EDUCATIONAL AGENCY.—The term “high-need local educational agency” means a local educational agency or educational service agency—

(A) that serves not fewer than 10,000 children from low-income families;

(B) for which not less than 20 percent of the children served by the agency are children from low-income families;

(C) that meets the eligibility requirements for funding under the Small, Rural School Achievement Program under section 6211(b) of the Elementary and Secondary Education Act of 1965 (20 U.S.C. 7345(b)); or

(D) that meets the eligibility requirements for funding under the Rural and Low-Income School Program under section 6221(b)(1) of

1 the Elementary and Secondary Education Act  
2 of 1965 (20 U.S.C. 7351(b)(1)).

3 (4) NONPROFIT HEALTHCARE CAREER PATH-  
4 WAY PARTNERSHIP ORGANIZATION.—The term  
5 “nonprofit healthcare career pathway partnership  
6 organization” means a nonprofit organization fo-  
7 cused on developing career and educational pathways  
8 to healthcare professions, that shall include rep-  
9 resentatives of—

10 (A) the local educational agencies;

11 (B) not less than 1 institution of higher  
12 education (as defined in section 101(a) of the  
13 Higher Education Act of 1965 (20 U.S.C.  
14 1001(a))) with an established health profession  
15 education program; and

16 (C) not less than 1 community-based, pri-  
17 vate sector healthcare provider organization or  
18 other healthcare industry organization.

19 (5) SECRETARY.—The term “Secretary” means  
20 the Secretary of Education.

21 (c) GRANTS AUTHORIZED.—

22 (1) IN GENERAL.—The Secretary is authorized  
23 to award grants, on a competitive basis, to eligible  
24 recipients to enable the recipients to develop and im-  
25 plement programs of study to prepare middle school

1       and high school students for postsecondary edu-  
2       cation leading to careers in the healthcare field.

3           (2) MINIMUM FUNDING LEVEL.—Grants shall  
4       be awarded at a minimum level of \$500,000 per re-  
5       cipient, per year.

6           (3) RENEWABILITY.—Grants may be renewed,  
7       at the discretion of the Secretary, for not more than  
8       5 years.

9       (d) APPLICATION.—Each eligible recipient desiring a  
10      grant under this section shall submit an application to the  
11      Secretary at such time, in such manner, and containing  
12      such information as the Secretary may require, which shall  
13      include an assurance that the recipient will meet the pro-  
14      gram requirements described in subsection (f)(2).

15      (e) PRIORITY.—In awarding grants under this sec-  
16      tion, the Secretary shall give priority to—

17           (1) applicants that include a local educational  
18      agency that is located in an area that is designated  
19      under section 332(a)(1)(A) of the Public Health  
20      Service Act (42 U.S.C. 254e(a)(1)(A)) as a health  
21      professional shortage area;

22           (2) applicants that include an institution of  
23      higher education that emphasizes an interdiscipli-  
24      nary approach to health profession education; and

1           (3) applicants whose program involves the de-  
 2           velopment of a uniquely innovative public-private  
 3           partnership.

4           (f) AUTHORIZED ACTIVITIES/USE OF FUNDS.—

5           (1) IN GENERAL.—Each eligible recipient that  
 6           receives a grant under this section shall use the  
 7           grant funds to develop and implement programs of  
 8           study to prepare middle school and high school stu-  
 9           dents for careers in the healthcare field that—

10                   (A) are aligned with State challenging aca-  
 11                   demic content standards and State challenging  
 12                   student academic achievement standards; and

13                   (B) lead to high school graduation with the  
 14                   skills and preparation—

15                           (i) to enter postsecondary education  
 16                           programs of study in mathematics and  
 17                           science without remediation; and

18                           (ii) necessary to enter healthcare jobs  
 19                           directly.

20           (2) PROGRAM REQUIREMENTS.—A program of  
 21           study described in paragraph (1) shall—

22                   (A) involve a review and identification of  
 23                   the content knowledge and skills students who  
 24                   enter institutions of higher education and the

1 workforce need to have in order to succeed in  
2 the healthcare field;

3 (B) promote the alignment of mathematics  
4 and science curricula and assessments in middle  
5 school and high school and facilitate learning of  
6 the required knowledge and skills identified in  
7 subparagraph (A);

8 (C) include an outreach component to edu-  
9 cate middle school and high school students and  
10 their parents about the full range of employ-  
11 ment opportunities in the healthcare field, spe-  
12 cifically in the local community;

13 (D) include specific opportunities for youth  
14 to interact with healthcare professionals or in-  
15 dustry representatives in the classroom, school,  
16 or community locations and how these experi-  
17 ences will be integrated with coursework;

18 (E) include high-quality volunteer or in-  
19 ternship experiences, integrated with  
20 coursework;

21 (F) provide high-quality mentoring, coun-  
22 seling, and career counseling support services to  
23 program participants;

24 (G) consider the inclusion of a distance-  
25 learning component or similar education tech-



nology that would expand opportunities for geographically isolated individuals;

(H) encourage the participation of individuals who are members of groups that are underrepresented in postsecondary education programs in mathematics and science;

(I) encourage participants to seek work in communities experiencing acute health professional shortages; and

(J) collect data, and analyze the data using measurable objectives and benchmarks, to evaluate the extent to which the program succeeded in—

(i) increasing student and parent awareness of occupational opportunities in the healthcare field;

(ii) improving student academic achievement in mathematics and science;

(iii) increasing the number of students entering health care professions upon graduation; and

(iv) increasing the number of students pursuing secondary education or training opportunities with the potential to lead to a career in the healthcare field.

1           (3) PLANNING GRANT SET ASIDE.—Each eligi-  
 2           ble recipient that receives a grant under this section  
 3           shall set aside 10 percent of the grant funds for  
 4           planning and program development purposes.

5           (g) MATCHING REQUIREMENT.—Each eligible recipi-  
 6           ent that receives a grant under this section shall provide,  
 7           from the private sector, an amount equal to 40 percent  
 8           of the amount of the grant, in cash or in kind, to carry  
 9           out the activities supported by the grant.

10          (h) REPORTS.—

11           (1) ANNUAL EVALUATION.—Each eligible re-  
 12           cipient that receives a grant under this section shall  
 13           collect and report to the Secretary annually such in-  
 14           formation as the Secretary may reasonably require,  
 15           including—

16                   (A) the number of schools involved and  
 17                   student participants in the program;

18                   (B) the race, gender, socio-economic sta-  
 19                   tus, and disability status of program partici-  
 20                   pants;

21                   (C) the number of program participants  
 22                   who successfully graduated from high school;

23                   (D) the number of program participants  
 24                   who reported enrollment in some form of post-

1 secondary education with the potential to lead  
 2 to a career in the healthcare field;

3 (E) the number of program participants  
 4 who entered a paid position, either part-time or  
 5 full-time, in the healthcare field following par-  
 6 ticipation in the program; and

7 (F) the data and analysis required under  
 8 subsection (f)(2)(J).

9 (2) REPORT.—Not later than 3 years after the  
 10 date of enactment of this section, the Secretary shall  
 11 submit to Congress an interim report on the results  
 12 of the evaluations conducted under paragraph (1).

13 (i) AUTHORIZATION AND APPROPRIATION.—

14 (1) IN GENERAL.—There are authorized to be  
 15 appropriated \$100,000,000 for each of fiscal years  
 16 2009 through 2013 to carry out this section.

17 (2) ADMINISTRATIVE COSTS.—For the costs of  
 18 administering this section, including the costs of  
 19 evaluating the results of grants and submitting re-  
 20 ports to the Congress, there are authorized to be ap-  
 21 propriated such sums as may be necessary for each  
 22 of fiscal years 2009 through 2013.

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